DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DEVELOPMENTAL DISABILITIES PLANNING AND ADVISORY COUNCIL

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

(406) 449-3878

HELENA, MONTANA 59604

November 11, 1983

This is your working copy of Montana's 1984-86 State Plan for Developmental Disabilities Services.

Please direct questions about content and additional copies to:

449 (444 after December 5th) - 3878

Thank you!

DDPAC Staff

PLEASE RETURN

Montana State Plan for Developmental Disabilities Services (MSPDDS):

ERRATA:

*p. 2.15 appears twice as a result of a duplicating error.

*p. 3.1: the reference in the second paragraph: ...(see Appendix M, Section 132 (8) (B))., should read (see Appendix M, Section 102 (8) (B)).

*References to Council Goals in Table 4.2 are incorrect. These should read:

p.4.6: Plan-Year Objective D: (Ref.: Goal II, ...)

p.4.7: Plan-Year Objective E: (Ref.: Goal II, ...)

p.4.8: Plan-Year Objective F: (Ref.: Goal III, ...)

p.4.9: Plan-Year Objective G: (Ref.: Goal III, ...)

p.4.10: Plan-Year Objective H: (Ref.: Goal III, ...)

STATE OF MONTANA

STATE PLAN FOR DEVELOPMENTAL DISABILITIES SERVICES

FISCAL YEARS 1984 - 1986

Verner Bertelsen, Chairman

Montana State Developmental Disabilities Planning and Advisory Council

Clyde Muirheid, Staff Director

Mary Faye Boyd, Administrative Assistant

PROLOGUE

This State Plan for Developmental Disabilities will eventually cover two periods: the state fiscal years July 1, 1984 through June 30, 1986 and the federal fiscal years October 1, 1983 through September 30, 1986. The primary purposes of this plan are to present Montana State Developmental Disabilities Planning and Advisory Council (DDPAC) goals and objectives for these periods and to develop a perspective on what services exist and what services are needed for persons with developmental disabilities.

The Montana State Developmental Disabilities Planning and Advisory Council and the Interagency Planning Forum (IAPF) formulated the structure and major ingredients of this plan. Moreover, the cooperation of other state, public and many private agencies have contributed further to its content.

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FISCAL YEARS 1984 - 1986

STATE OF MONTANA

Submitted by:

The Montana State Developmental Disabilities Planning and Advisory Council

Submitted to:

The United States Department of Health and Human Services, Office of Human Development Services, Administration on Developmental Disabilities, Region VIII Office

This State Plan is a joint endeavor of the State Planning Council and the State Administering Agency for Developmental Disabilities.

John D. Lafaver, Director
Department of Social and
Rehabilitation Services

Verner Bertelsen, Chairman
Developmental Disabilities
Planning and Advisory Council

State of Montana
Office of The Lieutenant Governor
Helena 59620

GEORGE TURMAN
LIEUTENANT GOVERNOR

PROJECT NOTIFICATION AND REVIEW SIGNOFF

State Application Identifier (SAI) Number: MT830617-421-A-95 Date: July 18, 1983

PROJECT TITLE: 1984-86 Developmental Disabilities State Plan

APPLICANT AGENCY: Montana Department of Social & Rehabilitation Services - Developmental Disabilities Planning and Advisory Council

AGENCY ADDRESS: P. O. Box 4210, Helena, MT 59604

FEDERAL PROGRAM TITLE, AGENCY, & CATALOG NUMBER: 13.630

DHHS

AMOUNT OF FEDERAL FUNDS REQUESTED: $250,000.00

PROJECT DESCRIPTION: State Plan 1984-86

CONTACT PERSON: Clyde Muirheid PHONE: (406)449-3878

The State Clearinghouse makes the following disposition concerning the above:

X (Block 1) — No unresolved problems were identified by the State Clearinghouse in the review process of the above captioned project. This form must be attached to the application submitted to the federal funding agency.

____ (Block 2) — Attached are comments by the State Clearinghouse concerning the review process of the above captioned project. These comments and this form must be attached to the application submitted to the federal funding agency.

H. Agnes Zipperian, Manager
Montana State Clearinghouse

PLEASE RETURN THIS PORTION OF FORM TO:

Montana State Clearinghouse
Office of the Lt. Governor
Capitol Building
Helena, Montana 59620

SAI No. MT830617-421-A-95

APPLICATION OFFICIALLY SUBMITTED TO ADD / Region VIII on 15 Aug 83
(Federal Agency) (Date)

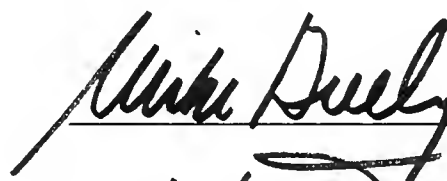
SUBMITTED BY DDPAC / SRS
(Agency) (Signature)

(Please inform the State Clearinghouse of application approval or denial by the funding agency.)

STATEMENT BY STATE ATTORNEY GENERAL

With reference to the Montana State Plan for Developmental Disabilities, for fiscal years 1984-86, submitted under the provisions of the developmental disabilities program, as amended by P.L. 95-602 and 97-35: Nothing in this Revision is inconsistent with State law.

NAME: Mike Greely, State Attorney General

SIGNATURE: 

DATE: 8/17/83

INTRODUCTION

This gathering of service and advocacy plans, interagency-planning activity, grant programs, evaluation procedures, definitions and statistics comprises the 1984-86 Montana State Plan for Developmental Disabilities Services. It also represents the Montana State Developmental Disabilities Planning and Advisory Council's contract with the Administration on Developmental Disabilities (ADD) for participation in the Basic State Grant Program.

Identification, needs assessment, planning and capacity building for individuals with developmental disabilities are tasks which call for constant attention and careful coordination. Persons with developmental disabilities usually lack the ability to obtain and coordinate services by themselves. They need more than one service from more than one agency and from more than one type of professional. Such complexity in service demands a capacity for coordination and cooperation at all levels of service provision. Most persons with developmental disabilities will also require services over a protracted period of time; and, in fact, will need services for their lifetime. Such pervasive needs demand both short and long-range planning capacities for the delivery of services.

Social, monetary and political demands place considerable pressure on the planning of services to persons involved in developmental disabilities. Moreover, agreement on terms and, as a consequence, eligibility for services are factors which compound service development and capacity building. In the State of Montana there are two definitions of developmental disabilities -- one state, one federal. These pressures and differences lie at the bottom of the various needs, various concerns, various capacities and various service gaps in the system of programs for which the State is, ultimately, responsible and with which DDPAC is involved as a planning and advocacy organization.

This State Plan presents the reader and user with facts, figures and other service and advocacy information, to facilitate the understanding of current services, the planning of new and innovative services, the building of needed capacities, and the employment of long-range strategies and tactics of service development and service delivery.

The differences in state and federal definitions notwithstanding, individuals involved in these disabilities are a segment of our population which has singular and important rights and needs. The user of this plan can, perhaps, see in it where the State is succeeding, and where it is not, in offering persons with developmental disabilities the opportunities they require and deserve for personal growth and progress.

REQUIREMENTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HUMAN DEVELOPMENTAL SERVICES
ADMINISTRATION ON DEVELOPMENTAL DISABILITIES
WASHINGTON, D.C. 20201

THREE-YEAR STATE PLAN INSTRUCTIONS FOR DEVELOPMENTAL DISABILITIES TITLE V OF P.L. 95-602 as amended

P.L. 95-602 requires that any State desiring to take advantage of Part C of the Act must submit a three-year State Plan. The approved State Plan is the basis upon which a State will participate in programs under Part C of Title V of the Act.

The three-year State Plan constitutes a State's presentation of its basic assurances, planning outcomes and service goals, and key activities for the year. The State Plan is the primary basis upon which ADD will monitor States' performance with respect to these assurances and other requirements. ADD's monitoring will focus on the designated State Agency's implementation of the three-year State Plan, including compliance with the plan and its use in planning, operations and service delivery.

This three-year plan for developmental disabilities will be effective October 1, 1983, covering fiscal years 1984, 1985, 1986. At a minimum, the State's Plan must contain:

* A description of the State Planning Council.

* A description of Council service and advocacy objectives.

* A description of priority services and of use of funds in these categories.

* A description of assessment and evaluation procedures and of plans for providing training of personnel to maintain quality of services for persons with developmental disabilities.

* Evidence that the State Council is addressing issues of service standards, protection of human rights, affirmative steps to include members of minority groups in service programs and utilization of volunteers and voluntary organizations.

PURPOSE

The purpose of the Montana State Plan for Developmental Disabilities Services is threefold. First, it is the intent of the U.S. Congress that states develop a contract with the Federal government for receipt of funds offered under the Basic State Grant Program of Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act. Second, through this plan, the State advises citizens about the manner in which the Basic State Grant Program operates and about the nature of its goals, objectives and planning process. Third, the State's Plan can provide the ADD and the Secretary of Health and Human Services with reliable, useful information upon which to base current and future national policy regarding the Basic State Grant Program and the needs of persons with developmental disabilities.

The DDPAC, in developing and compiling this plan, has committed to administering federal funds, paid to the State of Montana under P.L. 95-602, to make a significant contribution toward strengthening services to persons with developmental disabilities. In pursuit of this obligation, the Council sets as its purposes the following initiatives:

* Provide a forum for consumer and professional involvement in policy and priority determinations.

* Provide the means for exploring all avenues regarding the provision of services through state, local, private and public agencies.

* Specify in writing the objectives it intends to address in each fiscal year and redefine, when necessary, these same objectives on or before October 1 of each year.

* Develop, in conjunction with state agencies serving persons with developmental disabilities, a three-year State Plan which sets forth service goals and service priorities for that period.

* Work to foster and facilitate the integrated short and long-range planning and coordination of services capacities of all public developmental disability agencies.

The following pages contain, then, the contributions of DDPAC and other agencies, public and private, to service maintenance and service development for the period 1984-86.

SECTION 1

DEVELOPMENTAL DISABILITIES:

DEFINITION AND IMPACT

SECTION 1

DEVELOPMENTAL DISABILITIES: DEFINITION AND IMPACT

The State of Montana provides, through its various subagencies, a variety of developmental and support services to persons with developmental disabilities. Funding for these many different programs is, in general terms, derived from a combination of State dollars and Federal Assistance monies. The State delivers and/or oversees these services on the basis of categorical disabilities and eligibility characteristics...factors which are given definition by State law and State Agency policies and procedures.

Under current statutes, the State definition profiles developmental disabilities by "condition " or "category":

> "'Developmental disabilities' means disabilities attributable to mental retardation, cerebral palsy, epilepsy, autism, or any other neurological handicapping condition closely related to mental retardation and requiring treatment similar to that required by mentally retarded individuals if the disability originated before the person attained age 18, has continued or can be expected to continue indefinitely, and constitutes a substantial handicap of the person." (53-20-202, MCA)

With reference to this definition, each component of Montana's human service system defines eligibility for services on its own terms. Special education, vocational education, community mental health, institutional care, nursing home care, foster home care, community homes, protective services and others all have slightly different eligibility criteria. Persons are eligible or ineligible for needed services based on individual service-agency criteria. Within this framework of categorical disabilities and agency eligibility profiles, the State offers the bulk of the developmental disability services to persons involved in mental retardation. One essential criterion for mental retardation in Montana is IQ. Currently, the upper level is set at 69.

In addition to statutorily established treatment programs and support services, the State of Montana also participates in the Basic State Grant Program under Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act. The Montana State Developmental Disabilities Planning and Advisory Council is the medium for this involvement, and it carries out the mandates of this Federally Assisted Program with the added authority of State Legislation (2-15-2204 and 53-20-206, MCA).

The Basic State Grant Program is designed to assure that persons with developmental disabilities receive the care, treatment and other services necessary to enable them to achieve their maximum potential. The system developed for this purpose is intended to coordinate, monitor, plan and evaluate service delivery and service outcomes.

In honoring this mandate, the State Council adheres to the Federal functional definition. To the extent that the State and its Agencies work with the Council, Montana also acknowledges this definition. Written into Federal Law in 1978, this definition, unlike the State's, makes no special mention of specific conditions; instead it looks at the pervasiveness and severity of the disability.

> A developmental disability is a severe, chronic set of functional limitations which results from any physical and/or mental impairment and which manifest itself before age 22, and which:
>
> 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
>
> 2. Is manifested before the person attains age twenty-two;
>
> 3. Is likely to continue indefinitely;
>
> 4. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:
>
>   a. Self-care;
>   b. Receptive and expressive language;
>   c. Learning;
>   d. Mobility;
>   e. Self-direction;
>   f. Capacity for independent living; and
>   g. Economic self-sufficiency; and
>
> 5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are individually planned and coordinated.

The net effect of having and working with two definitions is three groups of persons with developmental disabilities of whom the Council and the State should take cognizance. These groups are:

- The overlap population: The individuals who meet the criteria in both definitions are those who are mentally retarded, or those whose cerebral palsy, epilepsy or autism manifested itself prior to age 22 and is sufficiently severe that it limits the person's ability to function in several major life activity areas. Falling into this category will be all individuals currently living at the two DD institutions (BRSH and Eastmont), virtually all individuals currently living in group homes funded by the DD Division, all people in work activity type programs, and all children served by the DD Division.

- The State DD population only: Those individuals whose conditions are not severe enough to meet the criteria in the Federal definition. Included would be many persons living in semi-independent living settings, all DD persons living independently, many individuals in sheltered workshops, and most who are now working competitively.

- The Federal DD population only: Those individuals whose conditions are very severe but are not mental retardation, cerebral palsy, epilepsy or autism. In particular, this group would include individuals who are seriously disturbed emotionally, or who are seriously handicapped physically (including some sensory impaired persons) as long as they meet the criteria in the Federal definition (severe, chronic, manifestation prior to age 22, need for multiple services, etc.).

One can see that from the Federal (and State Council) perspective, developmental disabilities are severe, chronic mental and/or physical impairments which occur at an early age, are likely to continue indefinitely, and have a pervasive effect on the individual's functional abilities and on their need for services. The most immediate impact of this functional definition on the Council's planning and advisory roles is the necessity to talk to and coordinate with not only the traditional State Developmental Disabilities Program Agencies, but also with the many different state services such as Deaf and Blind Programs, Handicapped Children Services, Special Services (under the Office of Public Instruction), Aging Services, Corrections and Mental Health Services. With the onset of its 1984 Plan Year, the State Council will again respond to this increased planning and advocacy responsibility under a set of goals, objectives and activities (see Section 4 of this Plan).

Because of this "expanded" definition, the DDPAC has the major task of determining the scope of the definition's impact and the location of State and Private Agencies which serve or could potentially serve persons identified under this broader grouping of disabilities. Appendix E presents a list of impairments which could be considered developmental disabilities under the Federal functional definition.

ESTIMATES OF POPULATION WITH DEVELOPMENTAL DISABILITIES

In Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), the U.S. Congress stated its findings as follows:

1. There are more than two million persons with developmental disabilities in the United States;

2. Individuals with disabilities occurring during their developmental period are more vulnerable and less able to reach an independent level of existence than other handicapped individuals who generally have had a normal developmental period on which to draw during the rehabilitation process;

3. Persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the person's needs;

4. General service agencies and agencies providing specialized services to disabled persons tend to overlook or exclude persons with developmental disabilities in their planning and delivery of services; and

5. It is in the national interest to strengthen specific programs, especially programs that reduce or eliminate the need for institutional care, to meet the needs of persons with developmental disabilities.

For the State of Montana, for its subagencies, for the State Council and for the many other public and private agencies, however, the task of determining numbers, characteristics and needs of all citizens with developmental disabilities remains a complex and demanding process.

Problems

Council estimates of developmental disabilities must consider the concept of functional limitations. Such an estimate is based on the assumption that, under the Federal definition, 1.57 percent of the general population is involved in developmental disabilities. This factor derives from a major study, in 1978, of the new Federal definition. Through a survey of raw data in the 1976 "Report of the U.S. Census Bureau Survey of Income and Education, researchers estimated the percentages and numbers of individuals who demonstrated functional limitations in the group of seven (7) major life activities set down in the Federal definition.

Appendices A and B offer estimated population figures using not only the Federal 1.57 percent factor, but also two other, "traditional" percentage figures. Estimates are seen here from both the state-wide and regional perspectives. Appendix B shows how dramatic the difference can be in estimates of persons with developmental disabilities.

These estimates are further compounded by the fact that:

1. Most statistical information on numbers of Montanans in any category is based on census information and the information gathered in a census is personal perogative (e.g., a person may not consider him/herself handicapped or disabled and would not answer a question that would identify them as such).

2. A specific question is not asked on most census questionnaires, the closest question asks if a person has a disability which prevents employment or use of public transportation.

3. Not all State Agencies explicitly determine how many of their clients are DD, since being developmentally disabled is not relevant for their eligibility determination process. For example, there is no accurate count of the number of DD individuals currently in special education or vocational rehabilitation.

4. When Agencies count the number of DD people being served, they are not generally using the Federal definition.

5. There is no fully unduplicated count available. For example, there is no way to know how many DD individuals are currently VR clients or how many VR clients in the past year were also served through DD Community Programs.

6. Persons with developmental disabilities who are not served directly through the State's Developmentally Disabilities community-based and institutional programs have been, historically, very difficult to identify.

There are many important issues (see Section 3) which State Agencies face in maintaining current services and in planning for unmet or insufficiently met service and support needs. These issues are compounded by the fact that, at best, the Council and the State must work with differing definitions and with inadequate population estimates.

In making estimates of numbers, characteristics and needs of persons with developmental disabilities in Montana, service and capacity planners can expect to find these persons in many different locations throughout the State. For example, persons with developmental disabilities would be in the following programs:

- DD Division funded community programs
- Special education programs inside and outside the State
- State operated institutions, particularly the Boulder River School and Hospital (BRSH)
- Private nursing homes

Services for these persons would fall into three (3) major groups:

1. Persons requiring intensive services.
2. Elderly persons requiring age-appropriate services.
3. Persons who can be expected to move or progress through services to increased independence.

In terms of where these persons receive services and in terms of their characteristics and needs, the State's population of persons with developmental disabilities is very diverse. Some of the more significant dimensions which contribute to this variety are:

- Age (pre-school, school age, working age adults, elderly)
- Specific type of condition resulting in the developmental disability (mental retardation, cerebral palsy, emotional disturbance, etc.)
- The specific areas of functioning that are limited (self-care, learning, receptive and expressive language, mobility, etc.)
- The severity of the disability.
- The presence of multiple handicaps, including behavior problems combined with mental retardation.
- The presence of medical complications.

- Sex
- Ethnic group
- Income level

A sensible estimate, in light of these different forces and concerns, of persons with developmental disabilities currently eligible for and receiving State supported services, or eventually to be needing treatment and support services, should make some specific assumptions. Children with developmental disabilities would be:

- All children receiving services from the DD Division.
- All children at BRSH, Eastmont, or Warm Springs.
- All children sent out-of-district or out-of-state for special education services.
- All deaf or blind children.
- Moderately or severely retarded children.
- All children in special education who are reported to be severely handicapped, if they have the following conditions:
  - emotional disturbance
  - deafness
  - blindness
  - orthopedic impairment
  - multiple handicap
  - other health impairment

  (Note that severe speech impairment and hard of hearing are not included.)

Adults with developmental disabilities would be:

- All adults served by the DD Division.
- All adults living at BRSH or Eastmont.
- Those adults not now receiving DD Division services but who are identified by the DD Division as needing services; this includes some people currently living in nursing homes, some people on a formal waiting list for an existing program, and some identified as needing a service who are not on a waiting list.
- Mentally retarded people served by the Rehabilitative Services Division.
- All adults considered to be DD by the Community Services Division.

Planners using this document should also note that not all persons served in Montana's Community-based Developmental Disabilities System are included in the 1.57 percent factor for estimated developmental disabilities. The reason for this is that not all mentally retarded, cerebral palsied, epileptic and autistic persons would fit within the Federal functional definition. All persons served under the State definition are, however, included in the data concerning services provided by State Agencies (see Section 3). There is then, a variance between total number of persons in the State and the total number of persons receiving services. Estimates used in past planning efforts, have also been inferrential and not descriptive in nature. Historically, such population estimates have been politically motivated...simply because the outcomes were always tied to revenues.

Since estimate factors have ranged from a "low" of 1.57 percent to a "high" of 8.5 percent (one in twelve persons), numbers, characteristics and needs have varied and flexed correspondingly. The results have been confusing, if not, at times, pointless. However, the 1.57 percent used by the Federal definition is the most empirical and, currently, most useful estimate for service planning purposes.

Working with the conflict of different definitions and in full recognition of the difficulty in counting who needs what services and why, the State Council continues to advocate for accurate identification of disabilities and comprehensive assessment of service needs. Beyond estimates of special populations, specific efforts at finding and identifying persons with human-service needs occur regularly in the State's various service agencies. Positions in State employment such as client-service coordinators and evaluation specialists work full-time to monitor and analyze the numbers (and needs) of persons with developmental disabilities. From these and other sources, the State can derive its profile of special populations and of related service needs, service gaps and service barriers.

For Montana's population of persons eligible for developmental disabilities services, the State works to maintain a record of persons receiving one or more services and a record of persons waiting for one or more services. These records are not necessarily unduplicated since persons can be in both counts; however, current numbers show more than 1,800 persons (adults and children) receiving one or more units of service in the State-supported developmental disabilities service network, and more than 840 persons on the State's "waiting list" for services. (Note: Currently, of the 840 persons on the waiting list, 46 percent are receiving at least one service).

Other Factors [1]

Montana's definition of developmental disabilities excludes approximately 85 percent of the special education students from established developmental disabilities services. However, research shows these services are needed. Special education students who are hard of hearing, deaf, orthopedically impaired, emotionally disturbed, visually handicapped, learning disabled,

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[1] REACH, Inc. Final Report on "A Model for Transitioning Special Education Students Into Adult Services"; 1983.

speech impaired or deaf and blind are not eligible for the long-term habilitation services offered eligible persons in the established service network. In many cases, it appears these ineligible persons have greater need for residential and vocational services than a number of persons with mild mental retardation. If the State of Montana were to adopt the Federal functional definition for developmental disabilities, these persons and many others would become eligible for established services. However, because there is already a substantial waiting list for these services, and in view of the increased cost of applying the expanded Federal definition, the State Council can anticipate the need for prolonged advocacy to promote systemic improvements for unmet needs.

Section 3 of this plan presents, in a standard reference format, the current and, where they exist, planned service activities of the State's various subagencies. The information is offered with the intent to inform and to, perhaps, facilitate planning and decision-making which will encourage increased capacities in present services and expansion to meet new and yet undocumented service needs.

Needed Capacities

In 1980, the State Council accomplished an assessment, by grant contract, of Montana's system of developmental disabilities services. One outcome of this study was a set of recommendations and a view of needed changes, improvements, strategies and related consequences for the State's service system. Most of these recommendations and new capacities still await planning and implementation activity. Appendix I contains a summary of this information. To the extent possible over the past two years, the DDPAC has shaped a number of its objectives around these findings. The 1984 Service and Advocacy Plan continues this same effort.

SECTION 2

THE MONTANA STATE DEVELOPMENTAL DISABILITIES PLANNING AND ADVISORY COUNCIL

THE COUNCIL

The Montana State Developmental Disabilities Planning and Advisory Council was established in 1971 by Gubernatorial Executive Order under the mandate of P.L. 91-517. In 1974, the Council received statutory authority (2-15-2204, MCA - See Table 2.1). During the same legislative session, 53-20-207, MCA, established five substate regional developmental disabilities advisory councils.

The state law establishes the members of the Council at a maximum of 22 members, all of whom are appointed by the Governor, and provides those members shall be:

- The director of the State Department of Institutions or a designee
- the director of the State Department of Social and Rehabilitation Services or a designee
- the director of the State Department of Health and Environmental Sciences or a designee
- the Superintendent of the Office of Public Instruction or a designee
- two members of the State Senate
- two members of the State House of Representatives
- four consumers or consumer representatives, at large
- one member each of the five regional developmental disability advisory councils (they must also be consumers or consumer representatives)
- one member each of the following professional disciplines: medicine, law, psychology, social work and special education.

In 1977, the legislature amended the state law changing appointments of council members from one-year terms to a rotation procedure. 2-15-2204 (3)(a)(b)(c), MCA described the appointments as follows:

> "(3) (a) Each member or his designee who served on the Council pursuant to subsection (2)(a) or (2)(b) of this section (i.e., agency directors or designees) shall serve for a term concurrent with his respective term as a director or the Superintendent of Public Instruction, as the case may be. Upon his removal from office, his or his designee's term as a member of the Council is automatically terminated and his successor in office or his successor's designee is automatically and member of the Council.
>
> (b) Each member who serves on the Council pursuant to subsection (2)(d) or (2)(e) of this section (i.e., legislators) shall be appointed or reappointed annually by the governor.
>
> (c) Eight of the members serving on the council pursuant to subsection (2)(c), (2)(f), or (2)(g) of this section (i.e., professionals, consumers, regional council representatives) shall be appointed or

reappointed annually by the governor to serve for terms concurrent with the gubernatorial term and until their successors are appointed. The remaining six members serving on the council shall be appointed by the governor to serve for terms ending on January 1 of the third year of the succeeding gubernatorial terms and until their successors are appointed."

State Law (53-20-206, MCA - See Table 2.2) charges the Council with the following duties:

- advise SRS, other state agencies, councils, local government and private organizations on programs for services to the developmentally disabled

- develop a plan for a statewide system of community-based services for the developmentally disabled

- serve in any capacity required by federal law for the administration of federal programs for services to the developmentally disabled.

To clarify these responsibilities, the Council uses the following "Policy Statement" concerning its role and responsibilities:

"We, the members of the Montana Developmental Disabilities Planning and Advisory Council, in recognition of our obligations and responsibilities to the people of Montana, and to those citizens who are developmentally disabled, and having taken cognizance of changing societal conditions, do hereby declare and affirm this statement of policy and purpose, as follows:

The Council shall continue to comply with the requirements of Federal and State Law and regulations and with those additional duties as prescribed by the Governor of Montana and as determined by the Council.

The Council shall strengthen its advisory function by remaining vigilant to the needs of persons with developmental disabilities. The Council will also be vigilant to assure that those needs are being met by efforts in the public and private sectors, and to the national and international trends which will facilitate these efforts. The Council shall actively provide reasoned, current and competent advice on these issues.

The Council shall continue to participate in planning activities and in the creation and formulation of the State Developmental Disabilities Annual Plan, and the Council shall emphasize the accuracy, appropriateness, realism and usefulness of the plan. The Council shall also review and comment on other plans which have implications for developmental disabilities.

The Council shall act as coordinator and catalyst in the provision of services by various public and private agencies, to the end that services will be complete as possible and as unduplicated as possible.

The Council shall solicit applications from and award grants to those agencies and persons who propose to perform high impact activity with potential for statewide significance and replication, including research,

investigation, analysis, demonstration and validation, and to other agencies and persons only when residual funds are available.

The Council shall encourage the strong and active advocacy of the legal and societal rights of persons with developmental disabilities, including, but not limited to, the rights of education, residential, employment and vocational, transportation and community activities and services.

The Council shall exert its active influence in the interests of perfecting, extending, changing and completing the network of developmental disabilities services and programs in Montana by public and private agencies and organizations.

The Council shall promote an adequate system to monitor developmental disabilities programs and services through a process of proposing, modeling, demonstrating, starting, encouraging and evaluating monitoring efforts on system-wide and individual bases, and by performing appropriate self-evaluation.

The Council shall continually review its working relationship with other public and private agencies, and shall adjust to the demands and opportunities of changing circumstances and conditions.

The members of the Council shall always be aware that their individual and collective efforts must be directed to the benefit of those Montanans with developmental disabilities."

ADOPTED, January 24, 1980

COUNCIL MEMBERSHIP (See Table 2.3)

In the Fall of 1982, the Governor's Council on Management published a report recommending the state consider reducing the size of the Council from its present 22 members. Table 2.4 discusses the implications of such a reduction, and it describes Council's current status for compliance with state and federal law.

COUNCIL STAFF

State law authorizes the Council to "employ and fix the compensation and duties of necessary staff", thus, Council hires and supervises staff. Council bylaws provide the Council Chair will supervise the Executive Director and the Executive Director will supervise all other staff. Salaries and grade levels for positions of Council staff are established according to the Statewide Personnel Classification and Pay Plan. The Montana Legislature authorized two full-time positions for the Council. Current staff are:

Clyde Muirheid -- Executive Director
Mary Faye Boyd -- Administrative Assistant

The Council's address is: DDPAC, P.O. Box 4210, Helena, MT 59604.

Council staff implement all planning, evaluation, advocacy, public awareness and other activities of the Council. These activities include staffing three standing committees and the Interagency Planning Forum; providing technical assistance to grantees and follow-along in project development; acting as liaison to the state legislature; and acting as primary planner for all major activities. Table 2.5 outlines the activities, responsibilities and qualifications of the two staff positions.

STATE ADMINISTERING AGENCY

The State Administering Agency is the State Department of Social and Rehabilitation Services, whose address is 111 Sanders Street (P.O. Box 4210), Helena, Montana 59604. The person who is responsible for the actions of the agency is John D. LaFaver, Director.

The functions and responsibilities of the Department of Social and Rehabilitation Services, as they relate to services for persons with developmental disabilities, include administration of the following programs:

- developmental disabilities
- public assistance
- medical assistance
- social services
- vocational rehabilitation
- aging services
- visual services
- children and youth services.

Within SRS, the Developmental Disabilities Division (DDD) is primarily responsible for the statewide, community-based developmental disabilities program. This program is a system of services which utilizes contracts with and grants to local non-profit corporations to provide services to persons with developmental disabilities and their families. Under state law, these services may include the following:

- evaluation services
- diagnostic services
- treatment services
- day care services
- training services
- education services

- employment services
- recreation services
- personal care services
- domiciliary care services
- special living arrangements services
- counseling services
- information and referral services
- follow-along services
- protective and other social and sociolegal services
- transportation services.

In addition, the DDD coordinates programs with other agencies for maximum and efficient provision of services.

RELATIONSHIP BETWEEN COUNCIL AND ADMINISTERING AGENCY

The Council is allocated under state law to SRS for administrative purposes only. Under this provision (2-15-121, MCA), SRS shall:

1. direct and supervise the budgeting, recordkeeping, reporting and related administrative and clerical functions of the Council,
2. include the Council's budgetary requests in the departmental budget,
3. collect all revenues for the Council and deposit them in the proper fund or account,
4. print and disseminate for the Council any required notices, rules or orders adopted, amended or repealed by the Council.

Departmental procedures have been developed by SRS to fulfill these functions with various appropriate divisions within the agency assigned specific tasks.

FISCAL CONTROL

Funds allocated under P.L. 95-602 as amended by P.L. 97-35 are granted to the State of Montana through the Council. These funds, plus any state matching funds, become a part of the Council's budget, which is a budget within SRS separate from all other SRS funds. All funds are received, disseminated and accounted for pursuant to the requirements of the Statewide Budgeting and Accounting System.

ADMINISTRATION OF THE STATE PLAN

Procedures for administration of all developmental disabilities services and programs in Montana are mandated by provisions within state laws and administrative rules. The State Plan is implemented primarily by the following agencies, which are all represented on the Council:

- the Department of Social and Rehabilitation Services (SRS)
- the Department of Health and Environmental Sciences (HES)
- the Department of Institutions (D of I)
- the Office of Public Instruction (OPI)

One other agency, the State School for the Deaf and Blind, is administered by the State Board of Public Education, which, at the present time, is not represented on the Council. However, the superintendent of MSDB participates in the Interagency Planning Forum.

The functions of SRS are indicated on page 2.4.

HES has, within its department, the Bureau of Maternal and Child Health, which administers such programs as handicapped children's services, crippled children services, and early and periodic screening and diagnosis. Program responsibility for the following programs also rests within HES: health planning and resource development and preventive health services.

The Department of Institutions administers all state custodial and correctional institutions serving, among others, the following persons who are included within the activities covered in the State Plan:

- the mentally retarded
- the mentally ill
- the aged
- emotionally disturbed children

In addition, the Department of Institutions administers funds allocated for community mental health services throughout the state.

The Special Services Division of the Office of Public Instruction is responsible for state-level administration of special education programs throughout the state, including the federal Education of All Handicapped Children Act (P.L. 94-142).

TABLE 2.1

2-15-2204. Developmental disabilities planning and advisory council. (1) The governor shall appoint a developmental disabilities planning and advisory council in accordance with the provisions of this section.

(2) The council is composed of 22 members and consists of the following:

(a) the directors of the departments of social and rehabilitation services, health and environmental sciences, and institutions, or their designees;

(b) the superintendent of public instruction or a designee;

(c) one recognized private professional in each discipline of medicine, law, psychology, social work, and special education;

(d) two members of the state senate;

(e) two members of the state house of representatives;

(f) four consumers or representatives of consumers or consumer organizations in the discipline of developmental disabilities; and

(g) one member of each of the five regional councils provided for in 53-20-207, who shall also be consumers or representatives of consumers or consumer organizations in the discipline of developmental disabilities.

(3) (a) Each member or his designee who serves on the council pursuant to subsection (2)(a) or (2)(b) of this section shall serve for a term concurrent with his respective term as a director or the superintendent of public instruction, as the case may be. Upon his removal from office, his or his designee's term as a member of the council is automatically terminated and his successor in office or his successor's designee is automatically a member of the council.

(b) Each member who serves on the council pursuant to subsection (2)(d) or (2)(e) of this section shall be appointed or reappointed annually by the governor.

(c) Eight of the members serving on the council pursuant to subsection (2)(c), (2)(f), or (2)(g) of this section shall be appointed or reappointed annually by the governor to serve for terms concurrent with the gubernatorial term and until their successors are appointed. The remaining six members serving on the council shall be appointed by the governor to serve for terms ending on January 1 of the third year of the succeeding gubernatorial term and until their successors are appointed.

(4) The council is allocated to the department for administrative purposes only and, unless inconsistent with the provisions of this section and 53-20-206, the provisions of 2-15-121 apply.

TABLE 2.2

53-20-203. Planning and advisory council. (1) The planning and advisory council may elect from among its members the officers necessary for the proper management of the council.

(2) The council may adopt rules governing its own organization and procedures.

(3) A majority of the members of the council constitutes a quorum for the transaction of business.

(4) The council may employ and fix the compensation and duties of necessary staff.

(5) A council member, unless he is a full-time salaried officer or employee of this state or any of the political subdivisions of this state, is entitled to be paid in an amount to be determined by the council, not to exceed $25 for each day in which he is actually and necessarily engaged in the performance of council duties. A council member is also entitled to be reimbursed for travel expenses incurred while in the performance of council duties as provided for in 2-18-501 through 2-18-503. Members who are full-time salaried officers or employees of this state or any political subdivisions of this state are not entitled to be compensated for their service as members but are entitled to be reimbursed for travel expenses as provided for in 2-18-501 through 2-18-503.

(6) The council shall:

(a) advise the department, other state agencies, councils, local governments, and private organizations on programs for services to the developmentally disabled;

(b) develop a plan for a statewide system of community-based services for the developmentally disabled; and

(c) serve in any capacity required by federal law for the administration of federal programs for services to the developmentally disabled.

TABLE 2.3

MEMBERSHIP OF THE STATE PLANNING COUNCIL

(Appointment Under Federal Law)

REQUIRED REPRESENTATION	REPRESENTATIVE	TITLE	ORGANIZATION	COUNCIL TERM
State Agency	John D. LaFaver	Director	Dept. of SRS	Term of Office
	Ken Card	Executive Asst.	Special Services/ OPI	Term of Superintendent
	Jerry Hoover	Administrator of MHRSD	Dept. of Institutions	Term of Director
	Dee Capp	Executive Asst.	Handicapped Children Services/HES	Term of Director
	Jan Brown	State Representative	State of Montana	1/7/87
	Judy Jacobson	State Senator	State of Montana	1/7/87
Higher Education	Dr. Dick Swenson	Director	Educational Research Institute	1/7/87
	Ken Card	Executive Asst.	Office of Public Instruction	Term of Superintendent
Local Agency	Bonnie Spurlock	Case Manager	District SRS Helena, MT	1/7/87
	Doug Schram	Special Education Teacher/Psychologist	North Central Learning Resource Center, Great Falls	1/7/87
Non-Governmental Agency	Ted Maloney	Director	Family Outreach Helena, MT	1/7/87
	Florence Lucas	President	Montana ARC	1/7/85
	Dr. Allen Hartman	Physician	Billings Clinic	1/7/87

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	Florence Lucas	President	Montana ARC	1/7/85
	Dr. Allen Hartman	Physician	Billings Clinic	1/7/87

TABLE 2.3 (cont.)
(Federal Law)

REQUIRED REPRESENTATION	REPRESENTATIVE	TITLE	ORGANIZATION	COUNCIL TERM
Immediate Relatives or Guardians of Persons with Mentally Impairing Conditions (cont.)	Verner Bertelsen	Grandfather	----------	1/7/85
	Donald Ochsner	Grandfather	----------	1/7/85
	Kannon Richards	Father	----------	1/7/87
	Linda Madson	Sister	----------	1/7/85
Immediate Relative or Guardian of Institutionalized DD Person	VACANT*			

*The one vacant position, immediate relative or guardian of an institutionalized DD person, called for in P.L. 95-602 has proven difficult to fill. This can be attributed, in part, to the fact that Montana has demonstrated substantial leadership in the area of deinstitutionalization of persons with developmental disabilities. Council will, however, continue its efforts to identify an interested parent or guardian of an institutionalized person with developmental disabilities to fill this position.

MEMBERSHIP OF THE STATE PLANNING COUNCIL

(Appointment Under State Law)

POSITION	REPRESENTATIVE	ADDRESS	COUNCIL TERM
State Representative	Verner Bertelsen	Rural Route #1 Ovando, MT 59854	1/7/85
	Jan Brown	906 Madison Avenue Helena, MT 59601	1/7/85
	Judy Jacobsen	1400 West Gold Street Butte, MT 59701	1/7/85
	J. Donald Ochsner	Broadus Route Miles City, MT 59301	1/7/85

TABLE 2.3 (cont.)
(State Law)

POSITION	REPRESENTATIVE	ADDRESS	COUNCIL TERM
State Agencies	John D. LaFaver	SRS 111 Sanders (P.O. Box 4210) Helena, MT 59604	Term of Office
	Ken Card	OPI - Special Services 1300 11th Avenue Helena, MT 59601	Term of Super-intendent
	Jerry Hoover	Dept. of Institutions MHRSD 1539 11th Avenue Helena, MT 59601	Term of Director
	Dee Capp	Handicapped Children's Services/HES Cogswell Building Helena, MT 59620	Term of Director
Private Professionals	Dr. Dick Swenson	1510 Highland Helena, MT 59601	1/7/87
	Bonnie Spurlock	316 N. Park c/o Lewis & Clark Social Services Helena, MT 59623	1/7/87
	Allen Hartman, MD	Box 2555 Billings, MT 59103	1/7/87
	Douglas Schram	RR 1183 Great Falls, MT 59401	1/7/87
Regional Councils	Linda Madson (Region I)	Box 373 Glasgow, MT 59230	1/7/85
	Joyce Curtis (Region II)	Box 699 Choteau, MT 59422	1/7/85

TABLE 2.3 (cont.)
(State Law)

POSITION	REPRESENTATIVE	ADDRESS	COUNCIL TERM
Regional Councils (cont.)	Kannon Richards	2206 Fairway Drive Billings, MT 59102	1/7/87
	Denise Kagie (Region IV)	2034 Locust Butte, MT 59701	1/7/85
	Florence Lucas (Region V)	1443 Jackson Street Missoula, MT 59801	1/7/85
Consumers	H.P. Brown	2733 Fern Drive Great Falls, MT 59404	1/7/85
	Ken Kronebusch	913 Mountain View Conrad, MT 59425	1/7/87
	Vonnie Koenig	430 Church Drive Kalispell, MT 59901	1/7/87
	Gary R. Marbut	310 Montana Building Missoula, MT 59802	1/7/85
	Ted Maloney	825 Helena Avenue Helena, MT 59601	1/7/87

TABLE 2.4

Implications of Reduction in Council Membership (Decreased Size of Council)

Staff Note: In October, 1982, the Governor's Council on Management made the following recommendation concerning the State Developmental Disabilities Planning and Advisory Council:

RESTRUCTURE THE STATE DEVELOPMENTAL DISABILITIES PLANNING AND ADVISORY COUNCIL

The Council advises the Department of Social and Rehabilitation Services, Department of Institutions, Department of Health and Environmental Sciences, and Office of Public Instruction on program planning. The 22 member group is too large to ensure effective leadership. Most of its work is devoted to awarding grants, but operating expenses account for more than one-third the current budget.

To streamline operations, the size of the council should be reduced. Furthermore, separate staffing should be eliminated and assistance provided by the Developmental Disabilities Division. Implementation will create a smaller, more effective council while increasing the funds available to improve services for the disabled.

The Council's response was, in part, as follows:

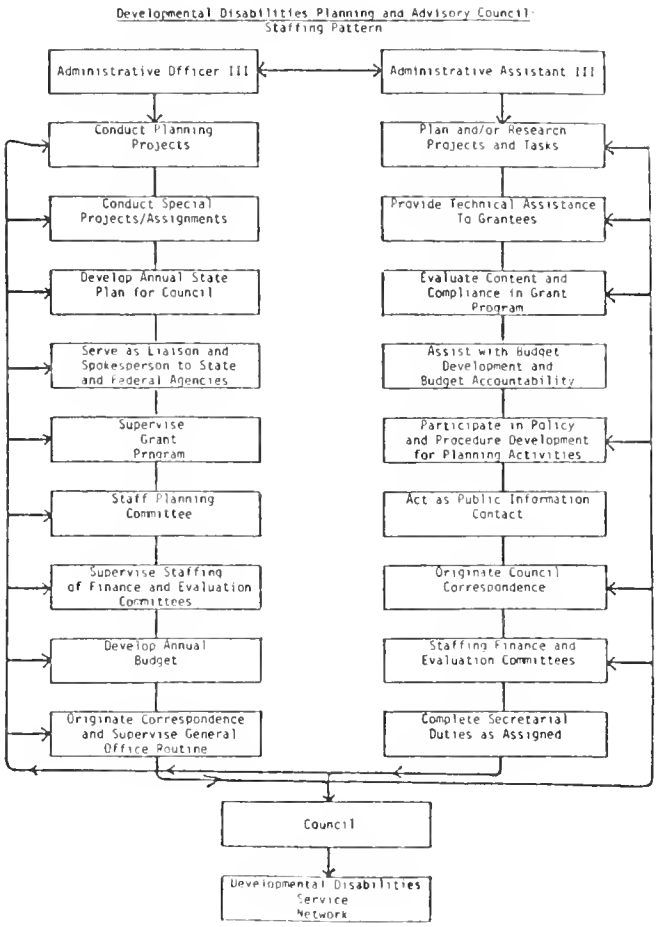
2-14-2204, MCA, mandates membership of 22 persons appointed by the Governor. Under current state law, therefore, Council must have 4 agency representatives, 5 private professional members, 4 legislative members, 4 consumers or their representatives, and 5 regional council members.

P.L. 95-602, Section 137 (a)(1) - (3), sets no numerical minimum or maximum on membership. Under federal law, all principal state agencies and all higher education training facilities, local agencies, nongovernmental services, and groups concerned with services for persons with developmental disabilities must be represented.

Furthermore, federal law requires at least one-half of Council membership to consist of persons with developmental disabilities or parents or guardians of such persons or immediate relatives of persons with mentally impairing developmental disabilities. Of this particular portion of council members, at least one-third will be persons with developmental disabilities; at least one-third shall be immediate relatives or guardians of persons with mentally impairing developmental disabilities, and at least one of these individuals shall be an immediate relative or guardian of an institutionalized person with a developmental disability. Council is currently out of compliance with federal membership requirements in that no current member is an immediate relative or guardian of an institutionalized person. (NOTE: See footnote in Table 2.3).

In the attempt to comply with the differing membership structures, both the Council staff and the Governor's Office are working to find a person to "fill both bills" opposite the state requirement for regional representation and the federal requirement for specific consumer representation. As the outcome of these efforts becomes apparent, Council staff will communicate with the Denver Regional Office of ADD. Ultimately, the conflict in statutes may have to be resolved by state legislative action in 1985.

TABLE 2.5

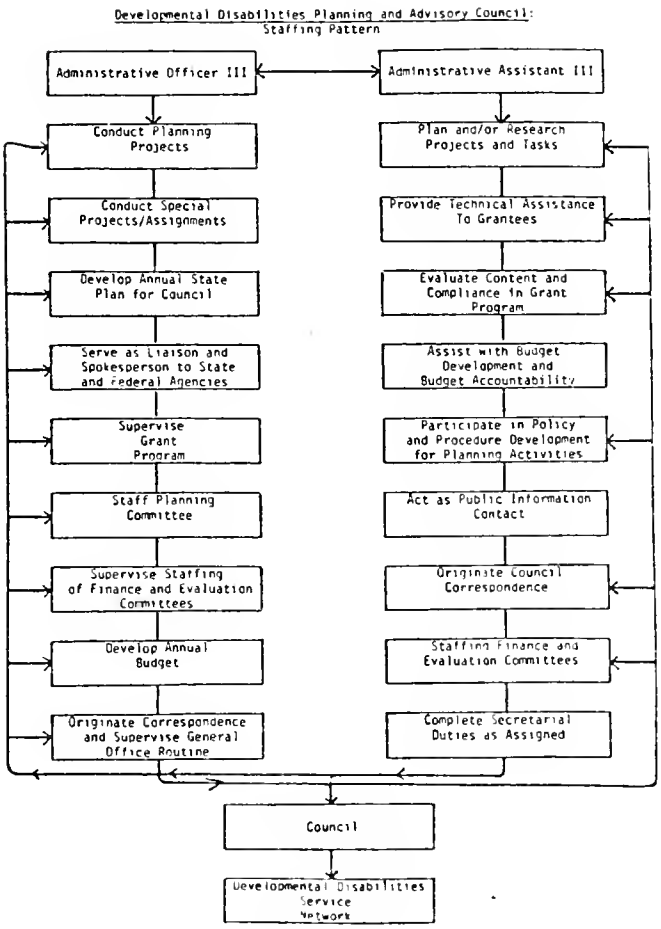


Staff Qualifications

The Administrative Assistant holds a B.S. in Business Administration, has four years experience in accounting and general business administration and three years in secondary education. The Staff Director holds a B.A. in Liberal Arts and an M.A. in Language with nine years of direct administrative responsibilities and eight years of direct-care experience in the field of community-based group-home and workshop programs for persons with developmental disabilities.

Both staff positions have been occupied by the same persons for over two years.

TABLE 2.5



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Both staff positions have been occupied by the same persons for over two years.

1983 - 1984
DDPAC
MASTER CALENDAR

Full Council Meetings

October 4-5, 1983 (Tuesday and Wednesday) -- Helena, Montana
*MCDD on Thursday and Friday, October 6-7

December 1-2, 1983 (Thursday and Friday) -- Helena, Montana
(Two day business meeting)

January 26-27, 1984 (Thursday and Friday) -- Helena, Montana
(Two day business meeting)

March 22-23, 1984 (Thursday and Friday) -- Helena, Montana
(Two day business meeting)

May 17-18, 1984 (Thursday and Friday) -- Butte, Montana
(One day tours and one day meeting)
*Montana State Special Olympics that weekend in Butte

June 29, 1983 (Friday) -- Helena, Montana
(One day business meeting)

August 17, 1983 (Friday) -- Helena, Montana
(One day business meeting)

Finance Committee Meetings (all in Helena)

September 23, 1983 (Friday)
November 18, 1983 (Friday)
January 13, 1984 (Friday)
March 9, 1984 (Friday)
May 4, 1984 (Friday)
June 15, 1984 (Friday)
August 3, 1984 (Friday)
September 14, 1984 (Friday)

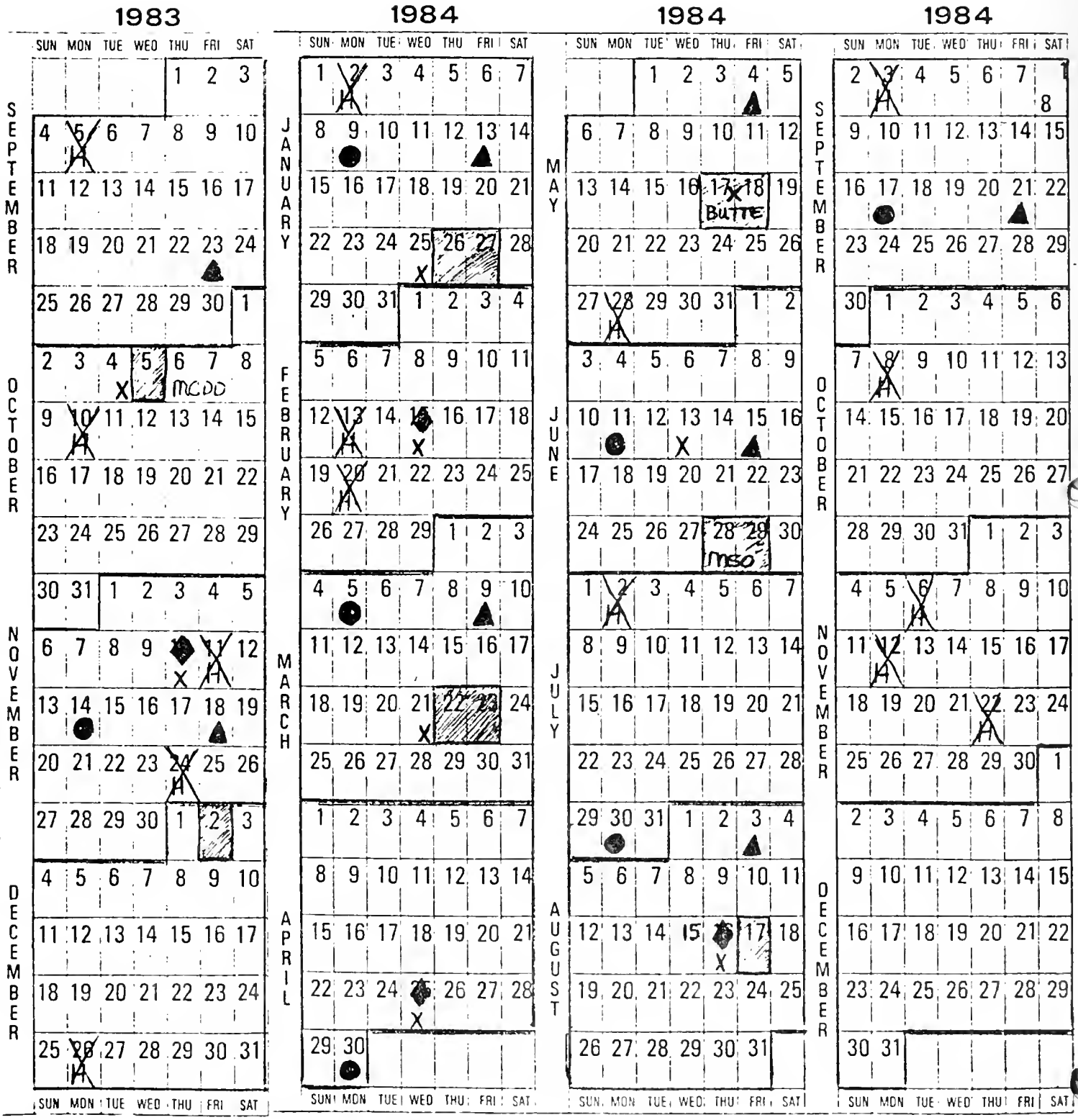
Evaluation Committee (all in Helena)

September 19, 1983 (Monday)
November 14, 1983 (Monday)
January 9, 1984 (Monday)
March 5, 1984 (Monday)
April 30, 1984 (Monday)
June 11, 1984 (Monday)
July 30, 1984 (Monday)
September 17, 1984 (Monday)

Planning Committee (IAPF)

September 14, 1983 (Wednesday)
November 9-10, 1983 (Wednesday, PC/Thursday, IAPF)
January 4, 1984 (Wednesday)
February 22, 1984 (Wednesday, IAPF)
April 25-26, 1984 (Wednesday, PC/Thursday, IAPF)
May 2, 1984 (Wednesday)
June 13, 1984 (Wednesday)
August 16, 1984 (Thursday, IAPF)
September 12, 1984 (Wednesday)

Table 2.6
DDPAC MASTER CALENDAR



◆ = IAPF
X = Planning Comm
▲ = Finance Committee
● = Evaluation Committee
H = Holiday
▨ = DDPAC

SECTION 3

SCOPE OF SERVICES

INTRODUCTION

INTRODUCTION

This section presents a view and description of services to persons with developmental disabilities throughout the state. The format used in most of the following plans is a product of collaboration between the DDPAC and the Interagency Planning Forum (IAPF) (see Appendix K for list of IAPF members). Table 3.1 outlines this format.

Council staff approached the many different service agencies throughout the state for this information. By publication date, the majority of organizations contacted had responded with the information requested. Here and there, services plans were submitted under different formats. Staff time and availability for this project prohibited the reformatting of these plans by publication date. As the plan year progresses, follow-up and revisions will occur as needed. Where specific service information is lacking, the plan contains a page indicating such. A further addition to this section will be charts for each service organization or agency indicating services provided and numbers of persons served in relationship to the four federal priority-service areas (see Appendix M, Section 132 (8)(B)). This state plan will undergo review at least quarterly. Consequently, descriptions of services should reflect, very closely, actual services, pending changes, and agency planning activity.

TABLE 3.1

1. Profile of Current Services (services in place):

   *Persons/developmental disabilities served; *access point for services; *agency budget; *how your agency applies federal definition of developmental disabilities (if applicable); *staffing in your agency.

Please Note: If possible, avoid lengthy description of services provided; summarize if appropriate; indicate any services which are based on federal definition or comment that no services relate to this factor.

2. List and describe, briefly, the generic services used or accessed by your agency or by developmentally disabled persons receiving assistance through your agency.

3. Implementation Schedules and Responsible Agencies:

   *existing services; *pending services (one or two-year priorities); *timelines (charted or otherwise concisely presented)

Please Note: Indicate here how your agency determines priorities for service development and/or delivery.

4. Profile of proposed or tentative agency expansion plans:

   *description of these possible services; *persons targeted for services (ages/disabilities/etc.); *service access points; *estimated service budgets.

Please Note: This can be a "wish list" of services your agency would like to foresee and/or develop over the next two bienniums.

5. Summary of Service Populations:

   *by state definition; *by federal definition

6. Service Gaps:

   *gaps by service and disability; *reason(s) for service gaps; *proposed and/or foreseeable resolutions to the gaps

7. Program Evaluation Procedures and/or Plans for New or Additional Evaluation programs:

   *evaluation of personnel; *evaluation of programs

Please Note: Include here reference to (explanation of) certification process(es) if applicable.

8. Special Programs:

   *services to poverty areas; *services to Native Americans; *volunteers in your developmental disabilities programs; *public awareness/outreach activities; *other special programs

9. Appendices:

   If applicable:

   *quarterly reports; *chart/list of current or documented service needs; *reference list of possible or future agency services; *reference list of service gaps; *other applicable or appropriate summaries; *reference list of specific generic services/contact persons.

SECTION 3.0

SCOPE OF SERVICES

AGING SERVICES

AGING SERVICES

The Community Services Division has been designated as the State Unit on Aging and is responsible for developing and administering the state plan on aging and for developing an intrastate funding formula to allocate Title III funds of the Social Security Act to Area Agencies on Aging. These specific activities are the tasks of the Contracts Bureau, which is a part of the Community Services Division. Services are provided through a network of area agencies, to whom the Contracts Bureau allocates funds and who in turn subcontract with various providers.

1. Profile of Current Services:

   Title III funds for aging services total approximately 3,154,465. Services are provided to all individuals age 60 and over and include transportation, information and referral, home health, legal services, congregate meals, and home-delivered meals. All services are provided by the area agencies through subcontracts with providers. There is no means test or eligibility criteria other than the age requirement of 60 years.

2. No generic services are used in aging services.

3. Services during the next two years will be essentially the same as outlined in #1 above.

   Service priorities are developed by analysis of area plans which are submitted by each area agency; the plans are developed for each area and priorities are determined by requesting input from consumer groups and holding public hearings.

4. There are no proposals for expansion of aging services.

5. States are allotted funds based on the ratio of population age 60 or over to the national population age 60 and older, therefore, services are provided to that age group only.

6. Service gaps that might be noted are:

   a. lack of group care facilities for the elderly,

   b. no specific services addressed to the mentally ill,

   c. lack of coordination with other transportation programs.

   Community Services Division is addressing the needs of the mentally ill in its 84-85 state plan. Further attempts will be made to coordinate all programs; particularly transportation, with other providers.

7. Area Agencies are assessed on a regular basis by staff of the Evaluation Bureau of the CSD. Personnel are evaluated by the performance appraisal system.

8. Services to native Americans are provided by the Area VII Agency on Aging.

SECTION 3.1

SCOPE OF SERVICES

BILLINGS AREA

INDIAN HEALTH SERVICE

OUTLINE OF SERVICE AVAILABLE TO THE NATIVE AMERICAN DEVELOPMENTALLY DISABLED POPULATION IN MONTANA BY THE INDIAN HEALTH SERVICE

1. Profile of Current Services - IHS

Indian Health Service direct services are available to all individuals of Indian and/or Alaskan native descent. IHS contract care services are available to those eligible individuals who meet the residence requirements established by Congress.

These services are provided at the various IHS hospitals and health centers located on the seven (7) Montana Reservations (see Attachment #1). Services include, but are not limited to: medical care, dental services, surgical and para-medical services which may vary as a function of location and staffing.

2. Special Services Available to Developmentally Disabled (Federal Definition) Individuals - Current Services

Developmental Assessment clinics are held for the purpose of on sight team evaluation of the developmentally disabled. This team includes pediatrics, psychiatry, nutrition, public health nursing, social services, physical therapy, occupational therapy, developmental specialist, as well as other medical and para-medical services when indicated.

Broad range medical and para-medical services are provided on a routine basis.

3. N/A

4. Services Plans Under Development - Plans are currently under study to develop a pilot resident home training program to provide long term training and support services for the families and agencies serving the developmentally disabled population. These services would be supplied in coordination and cooperation with the DAC program outlined above.

5. N/A

6. Service Gaps

Limitation on funds necessitate services being offered and delivered on a priority basis which is determined on the basis of relative medical need. This may result in services which are rehabilitative or non-emergent, being reduced or postponed. Individuals not meeting the requirements noted above may be denied services. Persons eligible for alternate resources may be requested to utilize that resource.

The acute and diagnostic needs of the individual are comparatively well met. Case management, home intervention and follow-up needs remain a concern. Shortages of trained personnel on location and limitations on funding result in significant service shortages in these areas.

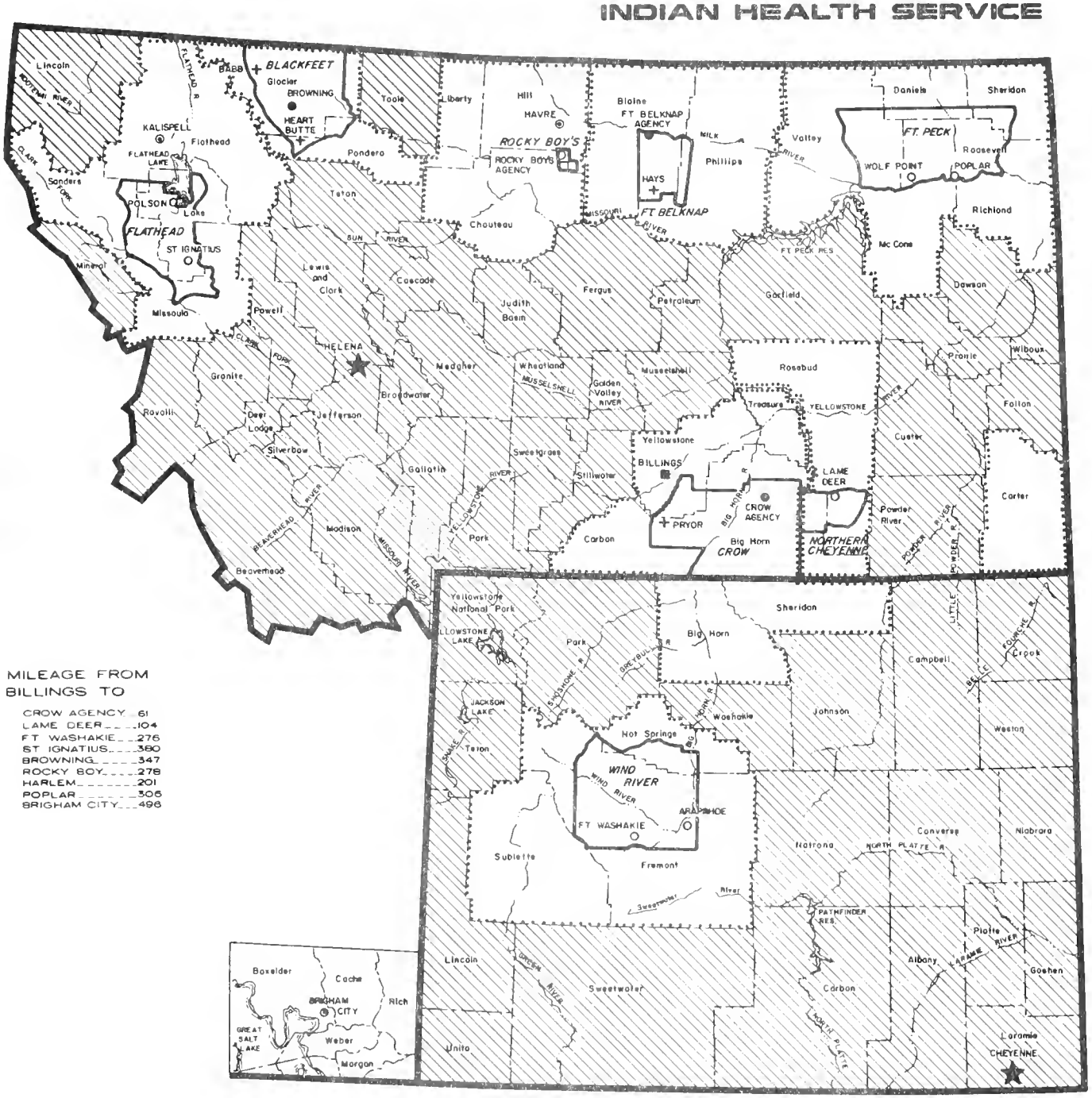
7. Program Evaluation

IHS facilities and services are reviewed and accredited by Joint Commission for the Accreditation of Hospitals and the Montana Foundation for Medical Care, as well as a systematic and regular evaluation and review by IHS itself.

8. N/A

ATTACHMENT 1

BILLINGS AREA
INDIAN HEALTH SERVICE



MILEAGE FROM BILLINGS TO

CROW AGENCY	61
LAME DEER	104
FT WASHAKIE	276
ST IGNATIUS	380
BROWNING	347
ROCKY BOY	278
HARLEM	201
POPLAR	306
BRIGHAM CITY	498

LEGEND

- AREA OFFICE
- PHS INDIAN HOSPITAL
- PHS INDIAN HEALTH CENTER
- PHS INDIAN SCHOOL HEALTH CENTER
- PHS INDIAN HEALTH STATION
- STATE CAPITOLS
- PHS INDIAN HEALTH DISTRICT OFFICE
- SERVICE UNIT BOUNDARIES
- INDIAN RESERVATIONS

SECTION 3.2

SCOPE OF SERVICES

BOULDER RIVER SCHOOL AND HOSPITAL

BOULDER RIVER SCHOOL & HOSPITAL

1. Profile of Current Services

Under state law (53-20-201 through 165 and 53-20-501, MCA 1979), the primary functions of Boulder River School and Hospital (BRS&H) are the care, treatment, training, education and necessary medical treatment of mentally retarded persons. Accordingly, BRSH provides programs of habilitation and treatment that are individualized to meet the specific needs of each resident in a manner that is professionally and humanely administered with due respect for each resident's personal dignity.

As a state-owned and operated residential facility, BRSH is an agency of the Montana Department of Institutions and administered through the Division of Mental Health and Residential Services. Figure 1 illustrates the administrative organization of BRSH. For the FY 84-85 biennium, BRSH has been authorized 441 FTE during FY84 and 441 FTE for FY85.

	FY84	FY85
State Funds	$10,791,099	$10,840,745
Federal Funds	20,050	17,172
TOTAL	$10,811,149	$10,857,917

It is anticipated that BRSH will provide services to 200 developmentally disabled persons during the biennium.

Admission for services at BRSH must comply with Montana's commitment law for the developmentally disabled (53-20-125, MCA or 53-20-129, MCA). The initial contact when considering admission to BRSH should be made through the Superintendent, phone (225-3311).

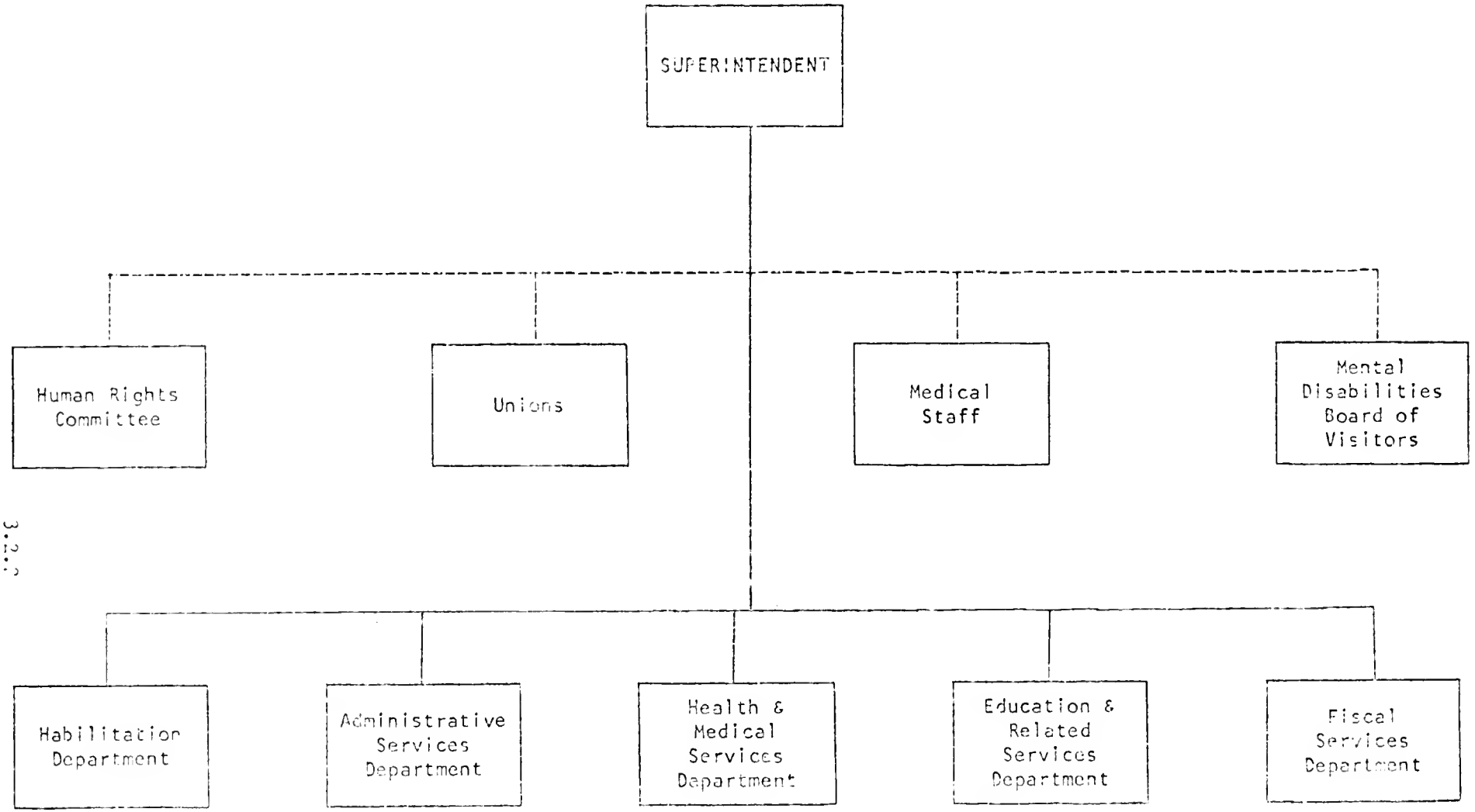
Organizationally, the services provided at BRSH are divided into 3 general program areas:

Administration Program

The Administration Program is responsible for providing overall direction for the operation of the facility. The program provides support services in the areas of fiscal, personnel, purchasing/warehouse, inservice training, clerical and other administrative functions.

Services and Support

The Service and Support Program is responsible for the total care of the people in residence at all times; it includes residential living supervision, training, and the provision of direct services to meet the basic needs of shelter, clothing, health care, food and provision of the comprehensive continuum of care for each person.



BOULDER RIVER SCHOOL AND HOSPITAL
ORGANIZATIONAL CHART
(1.1c)

Revised January, 1983

Developmental Program

The Developmental Program provides training, teaching, therapy, psychological and social services. Its primary responsibility is to provide these services to the people in residence; its secondary responsibility is to develop techniques and methods for treating the problems associated with mental retardation.

Services

The core treatment/training services offered at BRSH are as follows:

Education

The formalized training and education is conducted by certified special education teachers and has as one of its major purposes the objective of providing to residents an opportunity to gain physical, social, emotional and intellectual skills, in order that each person can develop to his individual potential.

Physical Therapy

Under a physician's orders, this department provides habilitative and rehabilitative services to the residents. These services include developmental exercises, correct positioning, feeding, training, group exercise, gait training, and use of modalities, and measuring for orthopedic shoes. Adaptive equipment and wheelchairs are provided for residents as needed. An orthopedic surgeon holds orthopedic clinics for residents referred by staff physicians. The therapists provide consultation services and inservice training to all staff and evaluate all residents at least once annually.

Psychology

Yearly formal evaluations are done for all residents. Other services as requested or indicated include direct therapy, staff consultation, parental consultation, habilitation planning, and consultation with outside agencies.

Audiology

Provide assessment of hearing capabilities, consultation on these findings, and approaches for professional and paraprofessional staff to use in connection with hearing problems. All residents receive impedance assessment during the year. For some, puretone testing, which requires training, is needed. Amplification is recommended for others.

Title I

This is a federally-funded program for children ages 3 to 21, which provides pre-verbal skill development, social language skills, sensory motor development and training for response to puretone and audiometric testing.

Speech Therapy

Provides training in receptive and expressive communication skills. This includes development of alternate communication systems in non-verbal individuals.

Recreation

Provides recreation therapy and training for all residents by providing movies, swimming, bus rides, holiday functions, physical education classes, pre-game and playground equipment training, training in gross and fine motor development, arts and crafts, game room skills, social and music skills.

Living Areas

Provides one-to-one formal training sessions, informal training sessions and activity training sessions carried on by Habilitation Aides and Habilitation Training Specialists. The training curriculum includes self-help skills, language (verbal or otherwise), object identification, shopping skills, social skills, eating and table manners, and elimination of maladaptive behaviors.

Medical

Provides x-ray, pharmacy, laboratory, nursing, infirmary and physician services. A wide array of medical consultants are available as needed. Provides annual physical examinations for each person and provides medical care as needed to each person.

Dental

Provides semi-annual examinations for each person as well as preventive care and repair of teeth as necessary. Provides consultation and inservice to cottage personnel in the area of oral hygiene.

Occupational Therapy

Provides therapy and training aimed at developing gross motor, fine motor, perceptual motor and functional skills of the upper portion of the body. Programs are developed to improve range of motion of the upper limbs, eating skills and oral function, head and trunk control, tone normalization, sensory integration and sensory motor integration and bi-manual function.

Social Services

Social workers write placement referrals, social histories and discharge summaries, do individual counseling for the people in residence and parents/guardians regarding rights or privileges, act as advocates for the people in residence, investigate placement possibilities and transport people on placement.

Foster Grandparents

The Foster Grandparents Program provides meaningful part-time volunteer opportunities for older persons to render supportive, person-to-person services to the children in such areas as; education, activities, love and affection, taking walks, feeding and socialization.

Religion

Provides non-denominational church services weekly, along with some individual and small group religious training.

2. Generic Services

As a full service residential facility, BRSH provides most services through indigenous professional staff. The two major areas where non BRSH facilities are used are medical consultants and hospital facilities, and community-based educational resources. During FY83, approximately 135 BRSH residents were seen in the community by medical specialists or received community hospital care. Five BRSH residents participated in special education classes at Boulder and Butte Public Schools. In addition to the above generic professional services, BRSH residents make extensive use of community recreational facilities, e.g., movies, bowling, parks and playgrounds, restaurants.

3. Implementation Schedule and Responsible Agencies

Services provided at BRSH are under the direction of an individualized habilitation plan for each resident. The plan is developed in accordance with (53-20-161, MCA). Prioritization of services is made by the residents habilitation team in accordance with individual needs. Each IHP identifies the department within the BRSH organization that is responsible for identified habilitation goals.

4. Expansion Plans

Service expansion is not planned during this biennium.

5. Survey of Service Population

Figure 2 presents the BRSH population according to sex, age group, level of retardation and social distribution.

6. Service Gaps

Several serious service gaps exist in the overall service delivery system for developmentally disabled that directly impact BRSH.

a. the need for appropriate community alternatives for BRSH residents;

b. the continued stigma that is attached to BRSH's program despite the high quality of service provided, creates problems in recruiting professional staff;

c. the general uncertainty regarding the future of BRSH has created morale and recruitment problems;

d. the need for additional physical and occupational therapy and educational staff to provide residents the services which meet their needs;

e. the need for small residential living units.

7. Program Evaluation Procedures

BRSH maintains an ongoing inhouse evaluation procedure that monthly monitors progress of residents within each program area. Additionally, BRSH is reviewed programmatically and/or fiscally by the following agencies: Board of Visitors, Department of Health and Environmental Sciences, State Fire Marshall, Office of Public Instruction, Department of Institutions, Professional Service Review Organization, Legislative Auditor, Department of Social and Rehabilitation Services.

8. Special Programs

As described in #1, BRSH has successfully integrated the Foster Grandparents Program into the overall programming of the facility. The contribution of these individuals has had a very significant positive impact on the quality of life for many BRSH residents as well as providing a necessary and meaningful job for the foster grandparents.

A second special program operated by BRSH is its Community Exposure Program. Under this program, BRSH residents participate in community activities, such as public restaurants and shopping trips with the dual goals of (1) providing a learning experience to the residents with appropriate community interaction and (2) exposing the public to the needs and capabilities of the developmentally disabled for the purpose of general education and awareness.

9. Appendices

N/A

BOULDER RIVER SCHOOL AND HOSPITAL

Levels of Retardation

	UNKNOWN	NORMAL	MILD	MODERATE	SEVERE	PROFOUND	TOTAL	PERCENT
MALES								
0-12	0	0	0	0	0	3	3	(1.4)
13-17	0	0	0	1	2	7	10	(4.5)
18-21	0	0	2	1	0	5	8	(3.6)
22-30	0	0	1	7	5	29	42	(19.0)
31-60	0	0	3	14	5	44	66	(29.9)
61-90	0	0	0	1	0	3	5	(2.3)
TOTAL	0 (0.0)	0 (0.0)	7 (3.2)	24 (10.9)	12 (5.4)	91 (41.2)	134	(60.6)
FEMALES								
0-12	0	0	0	0	0	0	0	(0.0)
13-17	0	0	0	0	0	4	4	(0.5)
18-21	0	0	0	0	0	3	3	(1.4)
22-30	0	0	1	3	0	26	30	(13.5)
31-60	0	0	1	7	3	35	46	(0.8)
61-80	0	0	0	0	0	03	03	(1.4)
TOTAL	0 (0.0)	0 (0.0)	2 (0.9)	10 (4.5)	3 (1.4)	72 (32.6)	87	(39.4)
BOTH SEXES								
0-12	0	0	0	0	0	0	0	(0.0)
13-17	0	0	0	1	2	11	14	(6.3)
18-21	0	0	2	1	0	8	11	(5.0)
22-30	0	0	2	10	5	55	72	(32.6)
31-60	0	0	4	4	8	79	112	(50.7)
61-90	0	0	0	0	0	0	0	(3.7)
TOTAL	0(0.0)	0(0.0)	9(4.1)	34(15.4)	15(6.8)	163(73.8)	221	(100.0)

RACIAL DISTRIBUTION

White.	199	90.0%
Indian	18	8.1%
Spanish-American	1	0.5%
Mixed	3	1.4%
TOTAL	221	100.0%

SECTION 3.3

SCOPE OF SERVICES

CENTER FOR THE AGED

MISSION STATEMENT
Fundamental Purpose, Philosophy and Principles

Purpose

The Center for the Aged is an institution of the State of Montana whose purpose shall be as follows:

1. To establish and maintain a Center for the care of persons suffering from illness or disabilities, primarily geriatric in nature, which require skilled nursing, intermediate care, personal care or domiciliary care.

2. To carry on educational activities related to rendering care to its patients or the promotion of health which, in the opinion of the Department of Institutions, may be justified by the facilities, personnel, funds, or other requirements that are or can be made available.

3. To promote and carry on scientific research related to the care of patients insofar as, in the opinion of the Department of Institutions, such research can be carried on, in or in connection with the Center.

4. To participate, so far as circumstances may warrant, in any activity designed and carried on to promote the general health of the citizens of Montana.

In order to fulfill these purposes, the Department of Institutions subscribes to the following basic philosophy and principles of operation.

Basic Philosophy

1. Spiritual Responsibility

   It is recognized that total patient care is concerned with the spiritual as well as with the physical and chemical restoration of human beings. The Center will give full cooperation with the pastors of patients to meet these spiritual needs and honor the Center's tradition of spirituality in action.

2. Health Service Responsibility

   Health of its citizens is one of the most valuable resources of the State and is invaluable to the individual. The Center will function as a State service enterprise to provide the high quality of health care and encompassing prevention, diagnosis and treatment of disease and rehabilitation of functions impaired by disease and age.

3. Charity Responsibility

   The Center, being a State institution, has charity as one of its obligations. To perform efficiently, the Center must make optimum use of existing resources for charitable purposes. Charity will also be extended in the form of admitting all who are in need of emergent care, irrespective of ability to pay.

4. Community Responsibility

The Department of Institutions is the governing authority of the Center and is the representative of the citizens of Montana and recognizes that the Center has its ultimate responsibility to the citizens of Montana which it serves. The Center will support and participate in cooperative efforts to improve the Center's services and health care of its patients, endeavor to keep the citizens of Montana informed of its achievements, and abide by the press codes established by the health care industry and news media representatives.

5. Patient Responsibility

Patients have the right to efficient, effective care, courtesy and considerations, comfortable and safe environment, protection of dignity and sense of privacy to the fullest extent attainable, considerate treatment of their visitors and fair assessment of charges related to the cost of services which they receive.

6. Medical Staff Responsibilities

Physicians and dentists who have been afforded the privilege to admit and/or treat patients at the Center have the following rights:

a. Preservation of physician-patient relationship.

b. Clear and definite guidance from the Department of Institutions relative to standards and the practice of medicine and conduct of medical staff functions.

c. The use of the Center's facilities and services to the extent available resources will provide which will facilitate the practice of medicine and amplify its effectiveness.

d. Promulgation of as full a partnership as is possible between the medical staff, executive management and the Department of Institutions developing objectives and policies and in providing effective services at the lowest possible cost.

7. Other Institutions and Health Care Facilities Responsibilities

The Center desires to share information and knowledge to the fullest extent permitted by prudent and reciprocal arrangements for the mutual advancement of our ability to serve. The Center will pursue any avenue which will implement integration of our cooperative efforts and services to the ultimate benefit of the public.

8. Vendor Responsibility

Those who supply the Center with products and services are entitled to fair and courteous treatment. The Center recognizes that it is advantageous to the Center and to the patients to foster equal opportunities to all qualified suppliers. The value of technical and professional information available from these suppliers is recognized and appreciated.

9. Educational Responsibility

The Center will carry on any educational activities related to rendering care to its patients or the promotion of health which, in the opinion of the Department of Institutions, may be justified by the facilities personnel funds or other requirements that are or can be made available.

SECTION 3.4

SCOPE OF SERVICES

COMMUNITY SERVICES DIVISION

COMMUNITY SERVICES DIVISION

1. The Community Services Division offers the following services to developmentally disabled persons in Montana:

   Case Management (to developmentally disabled persons only), home maker services, information and referral services, day care for children, family centered intervention, foster care for adults and children, protective services for adults and children, health related services to adults and children, institutional placement and counseling, licensing of community homes for the developmentally disabled, and the contracted services of family planning and legal services.

   The total budget for these services is $8,056,633 of which $4,647,296 comes from federal Title XX funds. It is not possible to break this budget down accurately as to what exactly was spent on services to the developmentally disabled.

   All services, except for contracted services, are delivered from county and district social service offices by the social worker and home attendant staff of those offices. The definition for developmentally disabled as used in Montana is "those persons with learning disabilities due to mental retardation, cerebral palsy, epilepsy, autism, or any other neurological handicapping condition closely related to mental retardation and requiring treatment similar to that required by mentally retarded individuals if the disability originated before the person obtained age 18, has continued or can be expected to continue indefinitely and constitutes a substantial handicap of the person."

   1,620 developmentally disabled persons received case management services from Community Services Division staff. 297 developmentally disabled persons received intensive protective services from Community Services Division staff. Our accounting system does not bring down the number of developmentally disabled persons who receive the other services listed above.

2. The Community Services Division does not use or access generic service programs except for children's day care services which were provided to 2,877 children.

3. The Community Services Division intends to offer the same services listed under #1 above. There will be special emphasis on coordinating and prioritizing services with other service delivery programs. Also, fiscal control of program expenditures is being emphasized.

   Service priorities are developed from several sources, such as public hearings on the state plan, consumer groups, field staff requests, and those needs identified by the Division and agency's evaluation systems. The selection of service priorities is made by supervisory personnel based on the above input. The ultimate authority for selection of prioritizing services rests with the Division Administrator and Agency Director.

4. The Community Services Division has not generally proposed expansion into new areas but is striving to maintain service levels that already exist. The plan is to prioritize services so as to achieve maximum effectiveness by emphasis on coordination, training and evaluation.

5. The Community Services Division offered case management and protective services to 1,917 developmentally disabled persons. As indicated above, counts for the other services are not available. Also, the expenditures for those specific services are not broken down in this Division's budget.

6. Service gaps that were noted in the Title XX state plan hearings were:

   a. lack of group care facilities for the elderly;
   b. no natural family planning programs;
   c. no employment related day care;
   d. not specifically addressing the needs of mentally ill; and
   e. not having specialized services to the Montana American Indian population.

   The Agency is conducting a survey on the location and special needs of the American Indians. The other program areas are being looked into to some degree by the Division and the Agency.

   A gap in services noted by the field staff in the area of developmentally disabled is a need for specialized intensive community care facilities for children and adults. The Developmental Disabilities Division is working with several proposals in this area to address these needs.

7. Evaluation of services offered by the Community Services Division is conducted by Community Services Division staff in conjunction with the Division's Evaluation Bureau and also fiscal evaluation by the Audit & Program Compliance Division of the Department of SRS.

   The basic service evaluation is based on computer reports established in a central reporting system known as ACE. There are specialized reports and evaluation systems for childrens foster care, certain contract services and protective services. Specialized program evaluations are conducted when needed and required.

   Evaluation of personnel is conducted by a performance appraisal system worked up by the employee and the immediate supervisor.

8. The Community Services Division has no specialized projects that have a significant impact on the developmentally disabled.

SECTION 3.5

SCOPE OF SERVICES

CORRECTIONS DIVISION

CORRECTIONS DIVISION

Developmentally Disabled Offender

1. Current Services

Community Corrections: Probation and Parole; Pre-Release Centers.

Services in use are those agencies generally found in the local area, i.e., mental health, drug/alcohol counseling, public assistance, Salvation Army, Good Will Industries, Vocational Rehabilitation, SRS, Adult Basic Education, Job Services Division.

Correctional Institutions: Montana State Prison; Pine Hills School; Mountain View School for Girls; Swan River Forest Camp; Montana Women's Correctional Center.

a. Physical needs are provided for all inmates including social and recreational aspects. There are no formal service delivery systems for physically handicapped inmates (residents) nor are the structures of the institutions of such a design that they will easily accommodate nonambulatory residents.

   Less than 1 percent of the institutional population suffers from a substantial physical handicap - either orthopedically impaired or suffering from a chronic or terminal illness. Consequently there are no established "special" physical education programs.

b. Vocational education available is limited due to program funding, the number of trained instructors, and the number of residents who wish to attend. There are no established "special" vocational education programs, however, there are teachers with special education credentials and they do provide individualized personal programs for the students which do include vocational training as well as academic.

   At Montana State Prison, the World of Work Program, which provides training in job search skills, needs to be several weeks in duration to help the inmates develop good work attitudes, work ethics and motivation. This program could coordinate with the Prison Industry program to help evaluate the individual's productivity and readiness for release.

c. In general the inmate population (adult and juvenile) shows normal I.Q. range but most students are functioning below an acceptable level. The director of education of Montana State Prison estimates that 10 percent of the entire prison population is learning disabled. The percentage of learning disabled is even greater among the residents within the juvenile institutions.

   Due to the level of custody required by the adult institutions it is not feasible to send adult inmates into the community to participate in educational programs provided by the public school systems. Consequently, all educational programming for the adult segment must

be brought into the prison or arranged through correspondence. The juvenile institutions may allow certain residents to attend classes in the community - thus they have access to a wide range of curriculum and special education not found within the institution.

d. Clinical services are provided to all residents. The director of clinical services at M.S.P. states that they do not have a significant population of offenders who are mentally retarded (less than 2 percent). The remainder of the institutional programs indicate that they have approximately 1 percent M.R. population. The area of greatest concern is the emotionally disturbed or psychopathic personality who functions fairly well but exhibits anti-social behavior or occasional loss of reality.

The Clinical Services section at M.S.P. is most concerned with the psychotic personality who may not be eligible for transfer to Warm Springs State Hospital. Their long-term need may be for additional psychological services.

Other programs which require assistance for the emotionally disturbed would be the recommendation of additional psychological services at Swan River Camp, for evaluation and consultation services and the recommendation to develop the foster grandparent concept for the younger residents in Pine Hills and Mountain View Schools.

2. Generic Services

a. Community Corrections:

Probation/Parole Offices and Pre-Release Centers use the full range of services available within their respective communities. Such services include: Social Rehabilitation Services; Job Service; mental health; public assistance; social security; Job Corps; alcohol and drug services; adult basic education; etc.

b. Correctional Institutions are traditionally responsible for the care of residents and therefore cannot utilize the full range of services until such time as the inmate is released.

TELS - Transitional Employment and Living Skills (CETA grant) funded through Department of Labor and coordinated by Department of Institutions to provide services for 20 low-functioning offenders.

PELL & BEOG - Federal grants-in-aid for education.

SSI - Social Security Insurance

WOW - World of Work career awareness program through Job Service and coordinated by Department of Institutions.

OPI - Adult basic education, public schools and university system.

3. Implementation Schedule

a. Community Corrections:

Ongoing use of community resources.

b. Correctional Institutions:

WOW - Ongoing services, continue present job function and expand program as set forth in section 4. (CETA funding to change to JTPA effective 10/1/83).

TELS - Continue present job function (CETA funding to change to JTPA effective 10/1/83).

4. Expansion Plans (Priorities)

a. Community Corrections:

1) Encourage existing prerelease centers to accept DD/MR offenders and build into existing contracts that DD/MR offenders will receive priority for acceptance into the center.

b. Correctional Institutions:

Clinical Services (2) Consider the need for additional psychological services at MSP.

Consider the need for additional psychological services at Swan River Camp.

Explore development of foster grandparent program at Pine Hills and Mountain View Schools (effective FY '85).

Prison Industry (3) May also use private consultant to establish Work Adjustment Training program within the prison and coordinate with the World of Work program to evaluate job readiness. Expect the World of Work sessions to run for six weeks. (Effective January 1, 1984).

Explore additional areas of industrial/vocational training.

5. Service population to include all incarcerated inmates: preference may be given to handicapped or developmentally disabled offenders for admittance into programs.

Breakdown of DD population correctional settings:

10%	handicapped
1%	mentally retarded
10%	learning disabled (adult)
25 - 35%	emotionally disturbed (adult)
less than 1%	hearing impaired
less than 1%	speech or language impaired
less than 2%	visually impaired
9 - 10%	health impaired
less than 1%	orthopedically impaired

6. Service Gaps

a. Community Corrections:

It is not known what percentage of adult and juvenile offenders on supervision are emotionally disturbed but it is estimated that the percentage figure would be nearly the same as those within the correctional facilities. Inmates released on supervision with conditions of mental health counseling may also require medication -- many of these persons do not qualify for Voc Rehab services or medical assistance.

7. Program Evaluation

a. Community Corrections:

The delivery of Probation/Parole services and residential treatment is in accordance to the manual of standards for Probation Services and Community Residential Services as established by the Commission on Accreditation for Corrections.

b. Correctional Institutions:

The facilities, personnel and programming within the institutional setting are established in accordance to the manual of standards by the Commission on Accreditation for Corrections.

8. Special Programs

TELS - Transitional Employment and Living Skills, a program to provide vocational evaluations and supportive services for those persons under court supervision or institutional custody who, because of physical, emotional, or sociological handicap may need assistance in becoming self-sufficient and employable.

SECTION 3.6

SCOPE OF SERVICES

DEAF/BLIND PROGRAMS

1. Profile of Current Services

The Department of Special Services is the entity within the Office of Public Instruction which is responsible for the supervision and coordination of special education within the state; the Title VI-C Severely Multihandicapped Deaf/Blind Program is a part of Special Services.

Deaf/Blind children are being served in the public schools throughout Montana in classrooms specifically for deaf/blind and also with the severely multihandicapped. They have the same supportive services, and in several instances a special aide is hired to work with those children. Funding and operation of day-to-day deaf/blind education programs has become the sole responsibility of the state. Title VI-C dollars no longer fund direct educational services for deaf/blind children.

The following Title VI-C services provided in Montana are based on federal definitions.

a. Technical assistance to schools, local service agencies and families of deaf/blind.

b. Workshops for teachers, teachers aides and support staff who work with deaf/blind children in L.E.A. Programs.

c. Training of personnel in participating agencies which are engaged in or responsible for services to deaf/blind children and their families.

d. Develop and disseminate materials and information to assist professional and allied personnel engaged in programs designed for deaf/blind children.

e. Coordinate services between local agencies to provide a continuity and continuum of services for deaf/blind children and young adults.

f. Consultative services to those persons directly involved in the lives of those children.

Mountain Plains Regional Center for Deaf/Blind has recommended that we focus priority on pre-school children, 0-5 (early intervention) and adolescents, 15-20 (transition to adult services).

Access Point for Services:

Criteria for deaf/blind certification.

Deaf/blind means concomitant hearing and visual impairments, the combination of which causes such severe educational problems for the child so impaired that the child cannot be accommodated in a special education program diagnosed solely for deaf or blind children.

The identification of a child as possibly having a hearing and vision problem is just the beginning of the diagnostic procedure that is put into motion once a child is referred for services in any of the

deaf/blind programs. To insure that each child may receive the best possible education and treatment program, a total assessment of the child's status must be determined. Diagnosing a child is the first step toward constructive planning. After the child has been referred for team assessment, he or she is placed in a suitable service program--one which is designed for his or her needs. As the student progresses through the educational program, he or she is referred to the Department of Vocational Rehabilitation/Visual Services for services in the event potential placement is vocational. The direction in program emphasis is transitional vocational programs.

Home programs for infants are provided through Family Outreach and Child and Family Services with technical assistance from the deaf/blind specialist.

Position assignment within the Title VI-C Severely Multihandicapped Deaf/Blind Program July 1, 1983 is:

June Miller, Deaf/Blind Specialist/Liaison

2. Generic Services

Attached see "Overview of Resources and Services for Deaf/Blind Children, Youth and Their Families". (Attachment 1)

3. Implementation Schedules and Responsible Agencies

Services for deaf/blind children and young adults are in place--services are not as complete, effective or efficient as could be, but a statewide continuity and continuum of services is being developed.

Those agencies most responsible to deaf/blind children are:

a. Department of Social and Rehabilitation Services

b. Office of Public Instruction

c. Montana State School for Deaf and Blind

d. Local Education Agencies

e. Easter Seal Center

f. Boulder River School and Hospital

g. Community Service providers

h. Medical Services (a most important area of service)

DEAF/BLIND REGISTER

Montana School for the Deaf & Blind	5
Skyline Center - Great Falls	10
Boulder River School & Hospital	10

OUTREACH

L.E.A. Programs

Billings	1
Kalispell	1
Glendive	1
West Yellowstone	1
Belgrade	1
Bozeman	1
Lodge Grass	1
Columbus	1
University Affiliated Program - M.S.U.	1
Choteau - Home Program	1
Whitefish - Whitefish Hospital	1
Hardin - Home - Terminally Ill	1
Billings - Nursing Home - Terminally Ill	1
Belgrade - Home - Home Program	1
Easter Seal Center - Great Falls Special Training Program and Work Activity Center	4
Helen Keller Center for Deaf/Blind Youths & Adults New York City	1

Total number of deaf/blind children and young adults - including three over the age of twenty-two

TOTAL: 44

4. Expansion Plans

No expansion of services are planned for the next two bienniums.

5. Summary of Service Populations

The learning problems of individuals with dual sensory impairments differ greatly from individuals having a single impairment. Many deaf/blind children possess other handicapping conditions, such as orthopedic and cardiac problems as well as intellectual and learning deficits. The problems that such children present are complex, even if there is not a complete loss of vision and hearing.

A multitude of individuals work with the deaf/blind persons. The following breakdown is the educational program and that is not complete in itself. Three of the teachers teach only deaf/blind students; the others teach deaf/blind along with severely multihandicapped. All therapists work with other children as well.

Teachers	13
Teacher Aides	21
Physical Therapists	8
Speech Therapists	8
Occupational Therapists	5
Mobility Trainers	2
Easter Seal S.T.P.	4

6. Service Gaps

Service delivery constraints exist in:

a. Group homes for deaf/blind young adults must be developed.

b. Prevocational programs must be expanded.

c. Work Activity Center at Easter Seal must be expanded to meet the needs of young adults who will soon graduate from deaf/blind programs in Great Falls.

7. Program Evaluation

Evaluation forms from Mountain Plains Regional Center attached. (Attachments 2 and 3).

8. Special Programs

Information pending.

ATTACHMENT 1

OVERVIEW OF RESOURCES AND SERVICES FOR
DEAF/BLIND CHILDREN, YOUTH AND THEIR FAMILIES

I. Federal/State Sponsored Programs

A. Social and Rehabilitation Services

1. Title I of the Social Security Act

-- Old Age, Survivors and Disability Insurance (SSI)

2. Title IV A and B of Social Security Act

-- Child Welfare Services

3. Title V of the Social Security Act

a. Crippled Children's Services
b. Maternal and Child Health Service

4. Title XIX of Social Security Act

a. Medicaid
b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

5. Title XX of the Social Security Act

a. Aid to Families with Dependent Children
b. Developmental Disabilities

6. Title XVI of the Social Security Act

-- Supplemental Security Income (SSI)

7. Rehabilitation Act of 1973

-- Vocational Rehabilitation - Basic Support

8. Vocational Rehabilitation Services

a. Helen Keller National Center
b. Independent Living Rehabilitation Services

B. Educational Services

1. Title I - Elementary and Secondary Education Act

-- Programs for the Handicapped in State Supported Schools

2. Title VI-B Elementary and Secondary Education Act

-- P.L. 89-313 and P.L. 94-142 - Education of the Handicapped Act

3. Title VI-C Elementary and Secondary Education Act

-- Regional Deaf/Blind Centers

4. Title V of Community Services Act

-- Head Start

C. Living Units and Housing Services

1. Title I Part C - Developmental Disabilities Services and Facilities Construction Act (P.L. 94-517)

2. Housing and Urban Development Act (HUD)

a. Section 202 - Loans for Housing for the Elderly or Handicapped
b. Section 232 - Nursing Homes and Intermediate Care Facilities

D. Education, Training and Information Services

1. Title III Part C - Comprehensive Employment and Training Act (CETA)

-- Youth Employment and Demonstration

2. Federal Assisted Training and Dissemination Program (Regional Resource Centers, etc.)

II. State/Local Services

A. Medical/Dental

1. Public

a. State and County Health Agencies
b. Hospitals and Clinics
c. Nursing and Extended Care Facilities

2. Private

a. Private Practitioners
b. Private Health Services
c. Nursing and Extended Care Facilities

B. Counseling/Psycho-Social

1. Public

a. State and County Mental Health Agencies
b. Social Service Agencies
c. Rehabilitative Service Agencies
d. Associations and Special Interest Groups (ARC, Parents of Deaf/Blind)

2. Private

a. Private Practitioners
b. Private Clinics and Agencies
c. Ministerial Counseling Services

C. Financial Assistance

1. Public (see Federal/State Sponsored Programs)

2. Private

a. Fraternal Organizations
b. Service Clubs
c. Church Sponsored Programs
d. Foundation Grants

D. Social and Rehabilitation Services

1. Public

a. Vocational Rehabilitation Agencies

1) General Services
2) Services for the Blind
3) Services for the Deaf

b. Social Service Agencies

c. Special Interest Agencies

d. Training, Work Adjustment Evaluation Workshops

e. Health and Hospital Systems

2. Private

a. Social Service Agencies
b. Special Interest Agencies
c. Training and Evaluation Workshop

E. Educational Services

1. State Departments of Special Education and/or Public Instruction

   a. Services Visually Impaired
   b. Services Hearing Impaired
   c. Multihandicapped
   d. Severe/Profound
   e. Deaf/Blind
   f. Psychological/Social Work Services
   g. Health and Ancillary Services

2. Local Education Agencies

   a. Special Education Programs
   b. Support Services

3. Private Education Programs

4. Church and/or Charitable Programs

5. Parks and Recreation Departments

F. Education, Training and Information Services

1. State and Local Education Agencies

2. Adult Education Programs

3. State University and College Programs

4. Free Schools and Public Libraries

5. Associations and Special Interest Groups

6. Health and Hospital Agencies

7. State and Local Department of Social Services

G. Living Units and Housing Services

1. Public (see Federal/State sponsored programs)

2. Private

   -- State and Local Sponsors

ATTACHMENT 2

MOUNTAIN PLAINS REGIONAL CENTER
FOR THE DEAF/BLIND

GENERAL EVALUATION PROCEDURES

PART A

1. Introduction

The outreach evaluation will consist of: (1) an initial survey of the state agency responsible for the outreach services in the state, the local agencies that provide the direct service to the children and (2) an on-site validation review of the state agency and a single local agency. For the initial survey, the state agency will complete a single questionnaire. The local agencies will complete one for each child. The on-site review will be conducted for only one child selected at random.

The initial survey instruments shall be reviewed by the state liaison person and an RCO staff member to validate the responses concerning an individual child and the services provided to that child. Should major discrepancies exist, the selection of that child for an on-site visit would have preference over a random selection. If discrepancies exist for two or more children, one will be selected at random for the on-site visit.

2. Sequence of Activities

a. The state liaison person shall prepare a numbered list of the children in outreach and a corresponding list of the local agency responsible for the direct service to the child, including the appropriate administrator's name.

b. The state agency responsible for the outreach services in the state will complete the instrument designed for its initial evaluation.

c. The liaison person will mail an evaluation instrument for each child to the local agency for it to complete and return to the liaison person. Ten days will be allowed for return.

d. The liaison person and a member of the RCO staff will review the returned instruments.

e. The liaison person and a member of the RCO staff shall select the local agency for which an on-site visit will be held. The selection will be made at random. (See introduction above).

f. The on-site visit will be made by the liaison person and an RCO staff member.

g. The RCO staff member will write a report of the on-site visit and of the total outreach program. That report will be made available to all appropriate individuals and agencies.

1.a. Describe the service that this agency provides for students in outreach, whether directly to the child, to the agency that provides direct services to the child, or other. If the service provided can be documented, i.e., copies of correspondence, travel itineraries and/or reports, please indicate.

The following list is intended to assist you in responding to this item:

1) Information on certification of eligibility.

2) Information on assessment and diagnosis of deaf/blind children.

3) Information on curriculum for deaf/blind children.

4) Information on teaching techniques for deaf/blind children.

5) Information about agencies which might provide needed services to the child or family.

6) Direct, hands-on teaching of the child.

7) Direct service to the family.

8) Inservice, consultation or technical assistance.

9) Other

ATTACHMENT 3

MOUNTAIN PLAINS REGIONAL CENTER
FOR THE DEAF/BLIND

GENERAL EVALUATION PROCEDURES

PART I

1. This instrument is designed so that the evaluation may be conducted as an "addendum" to the state compliance evaluation review. The state liaison person for deaf/blind, or a designee, should be included as a member of the state compliance team with the responsibility for evaluating the deaf/blind component, using this instrument. The travel expenses of the liaison person, or designee, shall be paid by the Regional Center. The state may choose to add other deaf/blind professionals to the team at its own expense. In states where it is not feasible for the evaluation of deaf/blind services to be an addendum to the state compliance evaluation team, a separate team will be organized by the state liaison person. The travel expenses of one person shall be paid by the Regional Center in this instance.

2. Responsibilities of the Evaluator:

   a. Conduct the evaluation on-site, at the time of the state compliance on-site visit.

   b. Respond to each item with appropriate comments in the space provided.

   c. Refer to the handbook, or guide, for assistance in interpreting each item on the instrument.

   d. Interview or meet with the project director, the head teacher, and others as needed, to obtain the information.

   e. Observe the program in action and the facilities in which it is housed.

   f. Review student records.

      (For d, e, f: Be aware of the different levels of programming, i.e., pre-school, education, and prevocational and daily living skills).

   g. Keep in mind that you are evaluating deaf/blind program services, not compliance.

   h. Submit a report, within thirty days of the on-site visit, to the Regional Center Office, to the program director, and to whomever else the state liaison person chooses.

The report will consist of a copy of the completed instrument and a narrative, utilizing the following format:

For each section:

Findings
Comments
Recommendations

To:

The program
The state liaison person
The MPRC

PART III

ON-SITE EVALUATION INSTRUMENT

Section 1.

Written statements of philosophy, goals and objectives, and program description

	Yes	No	Comments
1.1 The operational philosophy written by the agency concerning the handicapped is so stated that it pertains to the deaf/blind, or clearly includes the deaf/blind as a part of a larger group, such as the severely handicapped?			
1.2 There is a written statement of program goals, objectives and services to deaf/blind or severely handicapped that includes deaf/blind?			

Section 2.

Child Assessment and Placement

2.1 The certification of eligibility form (RCO-4) is on file?			
2.2 Reports from the following professionals are in the child's records:			
Ophthalmologist or vision specialist?			
Audiologist or hearing specialist?			
Deaf/Blind Education Specialist?			

	Yes	No	Comments
2.3 A professional, or team of professionals, to interpret reports competently for vision, hearing and deaf/blind education participated on the staffing and placement team (i.e., nurse, speech therapist, teacher of visually handicapped, teacher of aurally handicapped)?			
Section 3. Program Quality			
3.1 Baseline data has been collected, utilizing an appropriate scale, such as the Callier-Azusa, MCRI, teacher check list, etc.			
3.2 Baseline data, using the Callier-Azusa, have been collected on all students who are ten years of age or older to identify those for placement in a prevocational component?			
3.3 Data from the "Assessment of Pre-vocational and Daily Living Skills" have been collected on each student identified for placement in the prevocational component?			
3.4 The goals and objectives for the children are based on the diagnostic and assessment findings and recommendations?			
3.5 Activities are appropriate to reach the stated goals and objectives?			
3.6 The ratio of professionals to para professionals is such that the para professionals are receiving adequate supervision and direction?			

	Yes	No	Comments
3.7 The program allows for the students' development of social/affective skills?			
3.8 Recreation and leisure time activities exist?			
3.9 (Observe the space that is available for the deaf/blind program)			
The total area is sufficient?			
It is organized so as to offer maximum serviceability to the students?			
The noise level and visual stimulation have been controlled according to the needs of the children?			
3.10 (Observe the curriculum guides and curriculum materials that are available to the staff).			
Are they adequate to assist the staff in meeting the needs of the students?			
3.11 There is equipment and materials available to assist the staff in meeting the needs of the students?			
They are being appropriately utilized?			
3.12 There is a clear and observable expansion of the education program to include a pre-vocational/daily living skills component?			
3.13 The program provides for integration of the deaf/blind students with other handicapped children?			
3.14 The total program is effective in terms of its impact on the children's needs?			

	Yes	No	Comments
3.15 Program levels (pre-school, education, pre-vocational and vocational) exist as appropriate for age and developmental levels?			

Section 4

Continuity of Services

4.1 Criteria for entrance into each level of programming into which a deaf/blind student might be placed in this agency exist?			
4.2 Criteria for entrance into viable potential placement outside of the deaf/blind program in this agency have been identified?			
4.3 Criteria for exit from each level of programming within the deaf/blind program in this agency exist?			
4.4 Criteria for exit from other deaf/blind programs outside of this agency have been identified?			
4.5 Communication exists between this program and next potential program or agency?			
4.6 Life planning goals have been written for each student ten years of age or older?			
4.7 For students in the prevocational/vocational program the life planning goals project a work/living environment for beyond age 22?			

Section 5

Parent and Family Services

		Yes	No	Comments
5.1	The services to parents include a plan for informing the parents of community/state/federal resources?			
5.2	The parents have been offered and provided training and information on how to deal with their handicapped child?			

Section 6

In-Service

6.1	There has been an assessment of the training needs from which the needs of the deaf/blind staff may be drawn?			
6.2	The program has formulated a plan for training so as to meet the training needs of the staff?			
	That plan is being implemented?			
6.3	Information and media resources are sought and disseminated to staff?			
6.4	Staff attend local, state, regional and national conferences/workshops?			
6.5	Information gained by staff in attending a workshop or conference is shared with program staff?			

Section 7

Fiscal Accountability

		Yes	No	Comments
7.1	All staff positions have been filled or the agency is actively recruiting to fill vacancies?			
7.2	Separate accounting procedures are established for the Title VI-C funds?			
7.3	A clear audit trail exists to the extent that reported expenditures are identifable in the accounting system and budget balances are noted?			
7.4	Expenditures appear to have been made to carry out the intent for which they were proposed and contracted?			
7.5	The agency maintains an inventory of equipment purchased with VI-C funds?			
7.6	The agency has an identifiable system so that it may accurately report local, state and other (than VI-C) funds that support the deaf/blind program?			

SECTION 3.7

SCOPE OF SERVICES

DEVELOPMENTAL DISABILITIES DIVISION

1. Profile of Current Services

DEVELOPMENTAL DISABILITIES DIVISION

The Developmental Disabilities Division is the unit within the State Department of Social and Rehabilitation Services which is primarily responsible for providing community-based services to developmentally disabled individuals. The organizational structure of the Division is indicated on the Table on the next page. The Division was formed in 1976. From 1974 to 1976, community developmental disability services were provided through a bureau within the Rehabilitative Services Division of the Department. Prior to that time, community-based services for persons with developmental disabilities were administered through the Department of Institutions by Boulder River School and Hospital. Key legislation was passed in 1974, with substantially increased funding appropriated in 1975, for development of community-based services in conjunction with a deinstitutionalization effort.

The Division had a FY 1983 budget of over $12,800,000.00. Approximately 75 percent of these funds were supplied from the Montana State General Fund, and the remainder from federal sources including the Social Services Block Grant, Title XIX, and P.L. 95-602. The Division's FY 1984 budget is $14,000,000.00, of which 79 percent is from the general fund.

The Division spends roughly 87 percent of its total budget on direct services and 13 percent on Division and Regional Councils' operating expenses. There was a 13.3 percent budget increase from FY 82 to FY 83 and a 9.8 percent increase in funding from FY 83 to FY 84.

All persons who are determined developmentally disabled, as defined by State Law (53-20-202, MCA, 1979), are eligible for services. With the exception of family training and support services, for which the contractor determines eligibility, all other eligibility for services is determined through the county social services system. Although there is no financial eligibility requirement, this information may be gathered for administrative fiscal purposes.

Generally, the Division does not provide direct services to clients. However, the Division provides two exceptions to this. Case management, for a short time for persons leaving the institution. The Division uses a purchase of service contract system for the provision of services through local non-profit organizations. The Division provides staff training to the direct care staff of these service programs.

In June, 1983, approximately 1,700 persons were receiving services through local programs funded by the Division. These services consist of five major areas including adult habilitation, day training programs, residential services for adults and children, transportation, family training and support, and diagnosis and evaluation services.

On May 27, 1983, the Division reorganized and consolidated its function by legislative mandate. Consequently, the Division was reduced by 9 FTE's. The Division's administrative structure consisting of 5 regions was modified to a 3 area organization. See attached map for changes. The Regional Councils were maintained intact.

SERVICE DESCRIPTIONS

For contract purposes, the Division describes the services provided in the following manner. The Division does not imply that the following services are listed in least restrictive order. The least restrictiveness of a service is determined by the individual client, his/her specific needs, and the ability of the available services to meet those needs.

I. ADULT HABILITATION SERVICES

The purpose of the adult habilitation services is to provide functional training in non-residential settings which is based on individual habilitation plans. Adult habilitation services include training which addresses basic life skills, pre-vocational skills, work activities and sheltered employment skills. Training is generally directed toward skills pre-requisite or integral to vocational activities. Adult habilitation services direct their training activities toward movement of individuals to increasingly higher levels of independence.

Within this framework, training is provided to individuals based on their individual needs.

II. RESIDENTIAL SERVICES

The purpose of residential services is to provide a continuum of living arrangements to meet the needs of individuals and to facilitate their integration into community life with each individual's health, safety and well-being insured in each residential setting. Opportunities for socialization and the development of leisure time skills are also available.

The primary goal of residential services is the provision of instruction and intervention in accordance with the developmental model and the principal of normalization. The provision of service is directed toward maximum skill acquisition in order to increase personal independence.

Each person's individual habilitation planning team provides the general goals and specific objectives toward which each residential service directs its efforts. The individual habilitation plan, based upon the results of a formal assessment and identification of individual needs, also specifies the appropriate residential alternative in which services will be provided.

Each residential service coordinates its service activities with those of other specialized services such as: day habilitation and generic community services. Residential services include:

A. COMMUNITY HOMES

1. Adult Community Homes

Adult community homes which are licensed family-oriented living arrangements in which two to eight persons, not less than sixteen years of age, reside under supervision of community group home trainers. Each individual is provided habilitation services which include general care, supervision and guidance, and training.

Training focuses on the skills necessary for individual self help, functioning within the home, and interaction with the social and physical community environment. When appropriate, training focuses on the skills necessary for independent living.

2. Children's Community Homes

Children's community homes which are licensed family-oriented living arrangements in which two to five severely, multiple handicapped individuals, ages five to twenty-one, reside under the general care and supervision of community home staff. A home-like atmosphere is achieved while concurrently providing physical care and training in the areas of self-help skills, socialization, and community interaction.

B. SUPERVISED SEMI-INDEPENDENT LIVING AND TRAINING SERVICES

Semi-independent living and training services assure that individual receives habilitation services designed to enhance the independence of that individual who is at least eighteen years of age.

The individual habilitation planning team determines the readiness of each individual to receive these services according to established criteria as well as the degree and amount of supervision and training each individual will receive.

Each individual is provided habilitation services which include: supervision/guidance; home and community life training; generic/specialized service coordination; support; and follow-along in varying degrees and intensity according to each individual's needs.

C. SEMI-INDEPENDENT LIVING AND TRAINING SERVICES

Semi-independent living and training services assure that each individual receives habilitation services designed to enhance the independence of that individual who is at least eighteen years of age.

The individual habilitation planning team determines the readiness of each individual to receive these services according to established criteria as well as the degree and amount of supervision and training each individual will receive.

Each individual is provided habilitation services which include: supervision/guidance, home and community life training; generic/specialized service coordination; support; and follow-along in varying degrees and intensity according to each individual's needs.

III. TRANSPORTATION SERVICES

Transportation services are for the conveyance of developmentally disabled persons from a residential setting to a work setting and back; from a residential or work setting to another site in which they receive services such as medical, dental, physical therapy or leisure-time services.

IV. FAMILY TRAINING AND SUPPORT SERVICES

The purpose of family and children services is to provide training, information, and support services to families to assist in the development and care of their child who is developmentally disabled or at risk. These services are coordinated with other generic and specialized community services. The major goal of family and children services is to assist the natural or foster family in maximizing the developmental potential of their child and to maintain their child in the appropriate least restrictive environment.

Within this area of service, the following types of services are provided to eligible children and their families based upon their needs:

A. FAMILY TRAINING

The major goal of family training is to assist the natural or foster family in maximizing the developmental potential of their child by training the family to train the child. There are two types of family training:

1. Family Focused Training

Family focused training is directed toward enabling family members to function as independently as possible in providing or obtaining needed services for their child so that the need for family and children services is reduced or eliminated.

2. Child Focused Training

Child focused training is directed toward enabling family members to conduct specific skill acquisition or behavioral intervention programs with their child.

B. CLIENT TRAINING

Client training is direct training by staff with a child living in a natural or foster home for the purpose of skill acquisition or behavior deceleration. Major training responsibility is not shared by the parent or family members. Client training may take two forms:

1. Short-Term Training

Short-term client training terminates upon completion of a specific objective such as learning a skill or the elimination of an undesired behavior. The purpose of this training may be to demonstrate the effectiveness of the method, to begin shaping the child's behavior until the family thinks it can intervene, or to support the family by meeting one specific need which the family feels is essential.

2. Long-Term Training

Long-term client training is provided on an on-going basis. The agreement with the family for provision of this service would primarily be based on time. Within this designated time frame, specific programs would be developed, implemented and completed. As programs are completed, new programs would be developed. The family service staff would be involved in regular, frequent contact with the child.

C. RESOURCE AND SUPPORT

Resource and support are services provided by staff directly to a family or their child to assist in the development and maintenance of the family unit and/or the child. These services are individualized according to family needs and may include, but are not limited to the provision of:

D. SERVICE COORDINATION

These are services provided through working with other agencies on behalf of the family or child. The goal is to assist the family in obtaining all necessary and appropriate services and promote coordination of these services.

E. INFORMATION AND REFERRAL

Information and referral is the provision of a service by staff which:

directs families not currently served to the most appropriate available services which meet their needs. It may involve determining the family's needs, investigating availability and appropriateness of various services, explaining the options to the family, and contacting the agencies on behalf of the family; or

provides any information requested by families who have been previously served. This information may or may not be related to agency referrals.

F. RESPITE CARE SERVICES

Respite care services provide for temporary relief to natural and foster parents from the continuous care of an eligible family member who is developmentally disabled or "at risk".

V. EVALUATION AND DIAGNOSIS SERVICES

The purpose of evaluation and diagnosis services is to provide clinical inter-disciplinary functions designed to assess the level of development in terms of capability as well as deficiencies. The major purpose is to identify areas of needed services and programs relevant to individual's capabilities and deficiencies.

A. SERVICE COMPONENTS

Within this area of service, the following components of service are provided to any person who is suspected of having a developmental disability.

1. Intake

Intake includes the gathering of information about the individual and his family. This information is obtained from the family, other agencies and appropriate persons. A case history is developed containing all pertinent information including any existing evaluation reports and current service reports. Prior to the evaluation, the purpose and appropriateness of the evaluation is determined.

2. Evaluation

Evaluation and assessment determines if, and to what degree, an individual has developmental deficits, and what interventions and services are needed to enable the individual to move toward increasingly independent functioning. Assessment identifies the individual's present developmental level; the individual's strengths, abilities, and developmental needs; the conditions that impede the individual's development; and when necessary for treatment planning, the cause of the disability.

3. Treatment Plan

A written plan of intervention and action is developed on the basis of the assessment results with the participation of all concerned. The plan specifies goals and objectives. A continuum of development is identified outlining projected progressive steps and the developmental consequences of services.

4. Case Conference

A case conference is held regarding each individual who has had an evaluation. The case conference team is to include the designated case coordinator, appropriate professionals necessary to the treatment of the individual, the individual with the disability, and as appropriate, his parent, guardian or designated representative.

5. Case Coordination

A case coordinator is assigned at intake to each individual who is evaluated and who receives a treatment plan, to be the main contact person for the evaluated individual and his family. The case coordinator is responsible for follow along services needed by the individual.

6. Follow Along

A plan of follow-along services is written for each individual who is evaluated. The plan as a minimum has a schedule to check on referrals made. A plan for monitoring the progress of the individual's proposed treatment plan is developed as necessary.

Family and Children services are available statewide, with main and branch offices located throughout the state.

VI. INDIVIDUAL HABILITATION PLANS

Montana State Law (53-20-202, MCA, 1979) requires that each individual in Montana's community-based system must have an Individualized Habilitation Plan (IHP) within thirty (30) days of the individual's entry into a program. The IHP is an evolving written plan which states, in long and short-term goals, how the needs of an individual will be addressed, the names of persons and programs responsible and the specific time frames involved. The IHP is usually developed by an Individual Habilitation Planning Team consisting of the individual, the individual's advocate, the case manager, at least one person from each service program in which the individual participates, a representative from the institution from which the individual has not been formally discharged, if appropriate, and one person from the Division.

The person or program designated as responsible for each short-term goal must develop an Individualized Program Plan (IPP) which specifies a behavioral objective, and the procedures to be used to measure the individual's progress. Program plans are developed after the habilitation planning meeting.

VII. QUALITY OF SERVICES

Evaluation of programs consists of on-site visits and contract reviews conducted by staff of the Division. Regional Councils are involved in the evaluation of services. Each council has developed its own on-site evaluation procedures.

2. Generic Services

Due to the nature of Community-based services. The wide spectrum of needs of clients in the DD system, and the economic demands placed on disabled and non-disabled alike, all aspects of generic services are utilized by some percentage of clients each year.

3. Implementation Schedules

The Division, in cooperation with the Department of Institutions, Eastmont, Boulder River School and Hospital, the Office of Public Instruction, the Glendive and Sidney School District, Progress Inc., Westmont Home Care, Inc., Developmental Assessment Services, Richland Opportunities, Inc., deinstitutionalized sixteen (16) individuals from Boulder River School and Hospital and Eastmont Human Service Center.

This process involved the development of two (2) children's group homes, one in Sidney and one in Glendive to house eight (8) children left in the Eastmont Human Service Center Five Day Program. This program was discontinued July 1, 1983. The communities involved are developing educational programs for the clients.

One intensive community home was developed by Westmont for eight (8) adults from either Eastmont Human Service Center of Boulder River School and Hospital. Services to these eight (8) clients were developed at Progress, Inc.

The Division also is cooperating with Child and Family Services Providers and DDPAC to test and develop a specialized Foster Care Program. This development is in its initial phase.

4. Profile of Proposed or Tentative Agency Expansion Plans

Plans are currently being developed in Planning Phase I.

5. Summary of Service Population

The total number of individuals receiving services in each program detailed above is indicated in the following table.

Total Number of Individuals Receiving Services Through the Division in June, 1983

Program	Number
Adult Habilitation Services	1,101
Residential Services:	
Adult Community Homes	454
Children's Community Homes	51
Semi-Independent	224
Transportation Services	975
Family and Children Services	372
Respite Care	456

6. Service Gaps

Service gap information in Planning Phase.

7. Program Evaluation Procedures

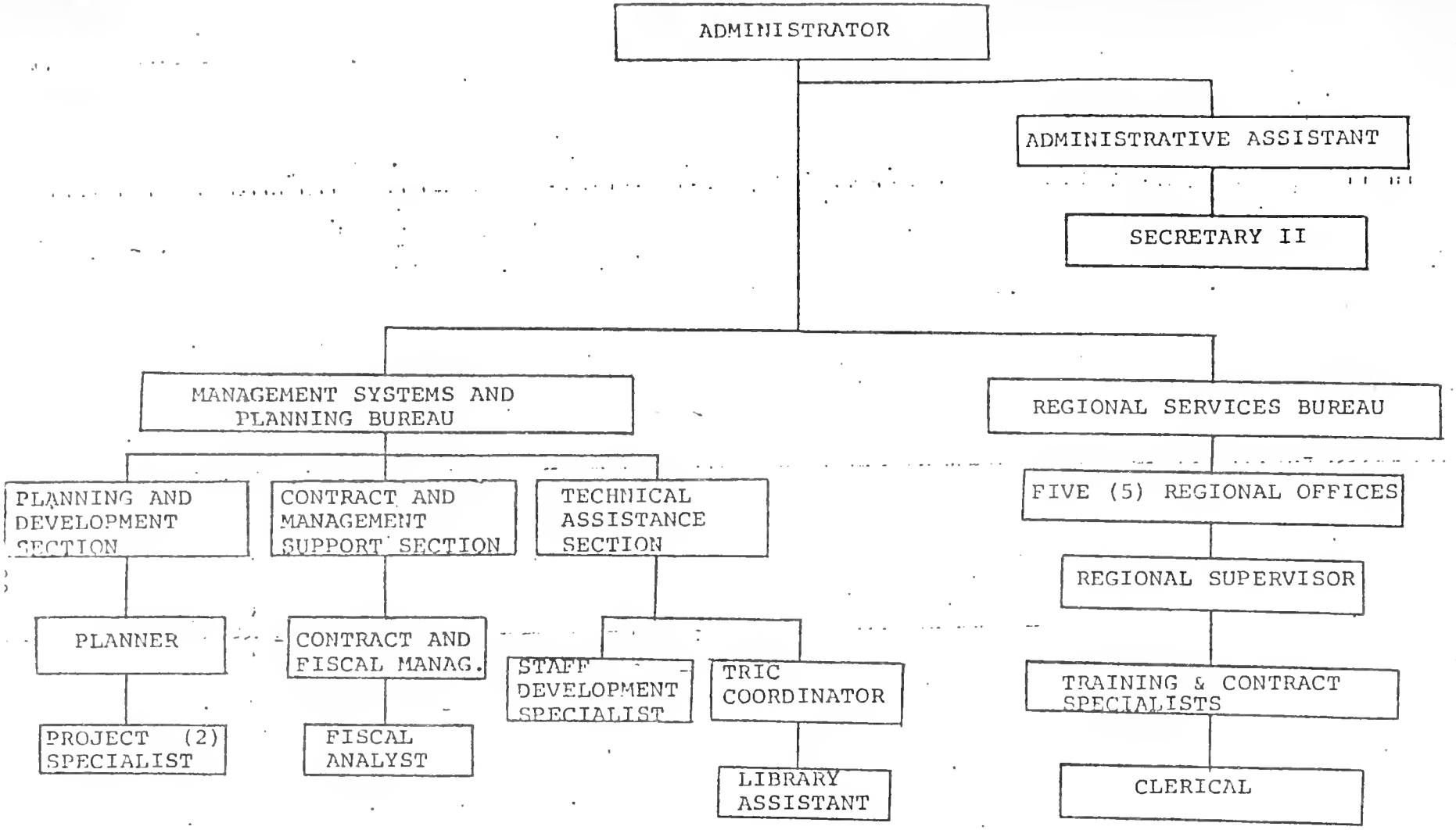
The Individualized Habilitation Planning Process in combination with the DD Division's Quarterly Review Process are examples of the evaluation process used for these services. Additional refinement and additions to the evaluation process are on-going.

8. Special Programs

The development, implementation and expansion of services for DD individuals utilizing a Federal Medicaid (Title XIX) Waiver is being phased in to the DD Service System. These services are being coordinated with other SRS Services and have a vast potential for continued development of additional services. Attached is a copy of the Medicaid Waiver Proposal.

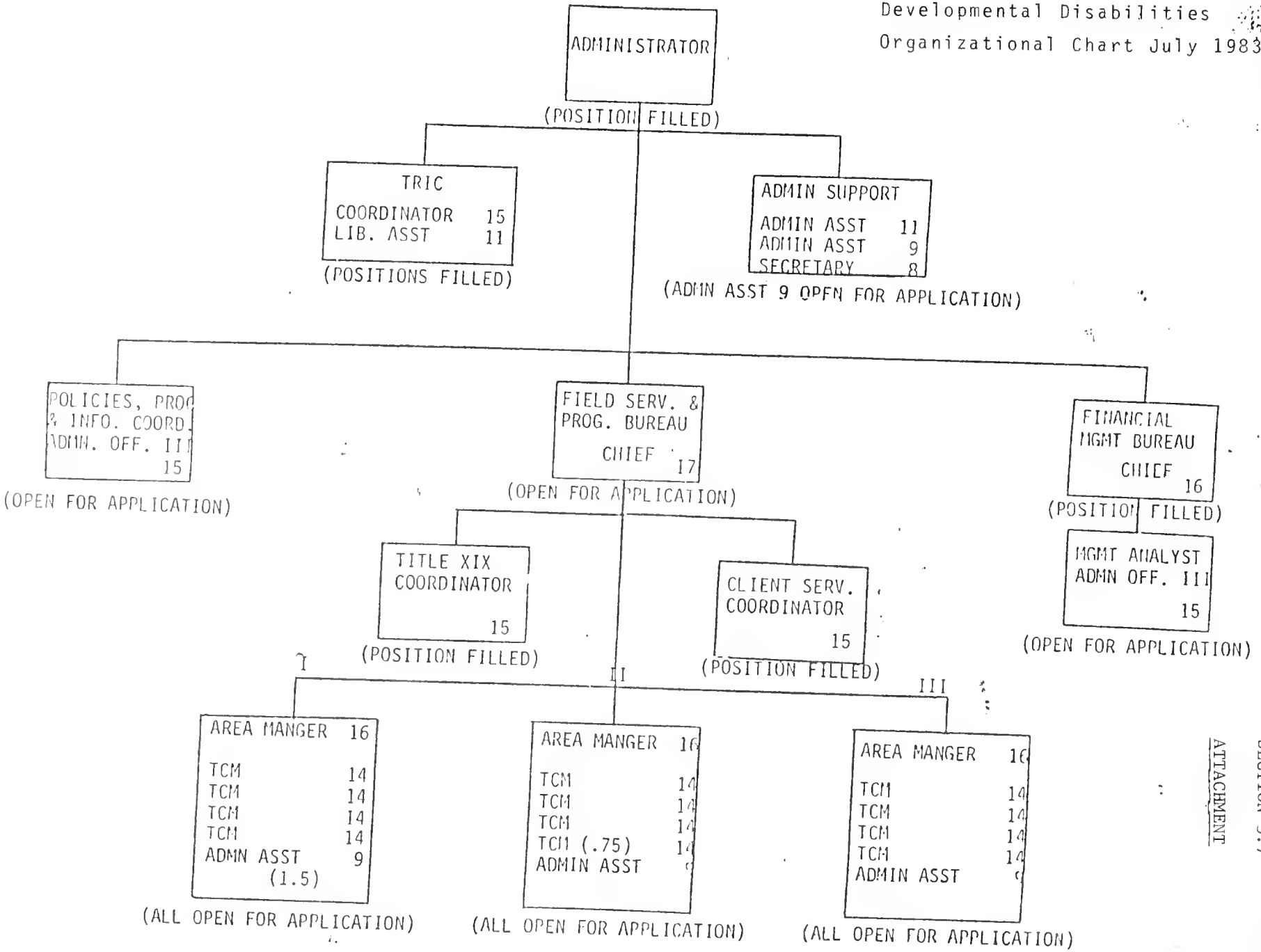
TRIC - Training Resource Information Council continues to be an on-going special program for the DD Division. The DD conference organized by TRIC is a yearly event that has proven to be a major forum for discussion of current issues in the DD Service System, both State and nation-wide. Attached is a copy of TRIC operating procedure.

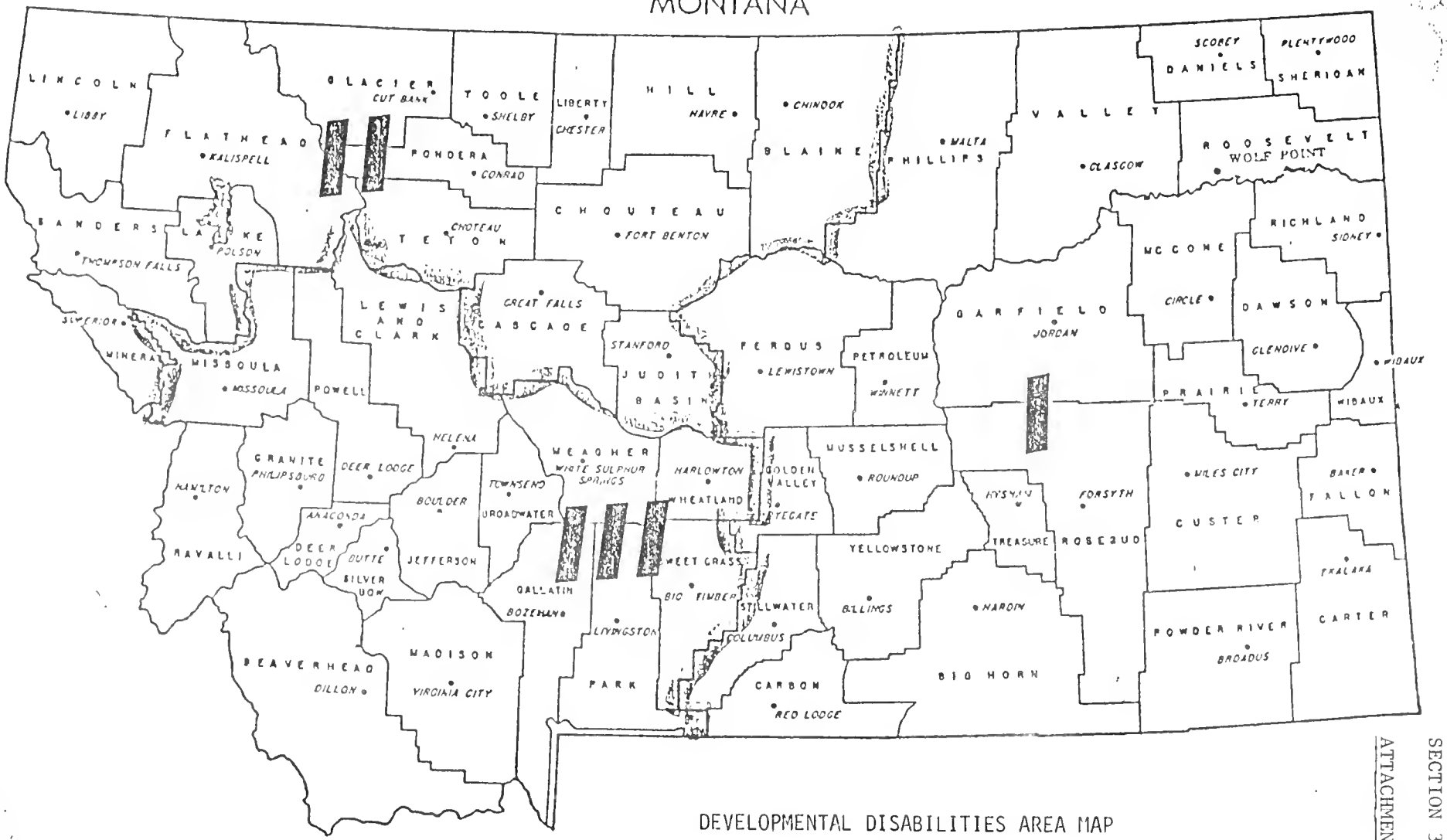
Additions to this category are in the planning phase.



Developmental Disabilities 1983
Organizational Chart
Before reorganization

Developmental Disabilities
Organizational Chart July 1983



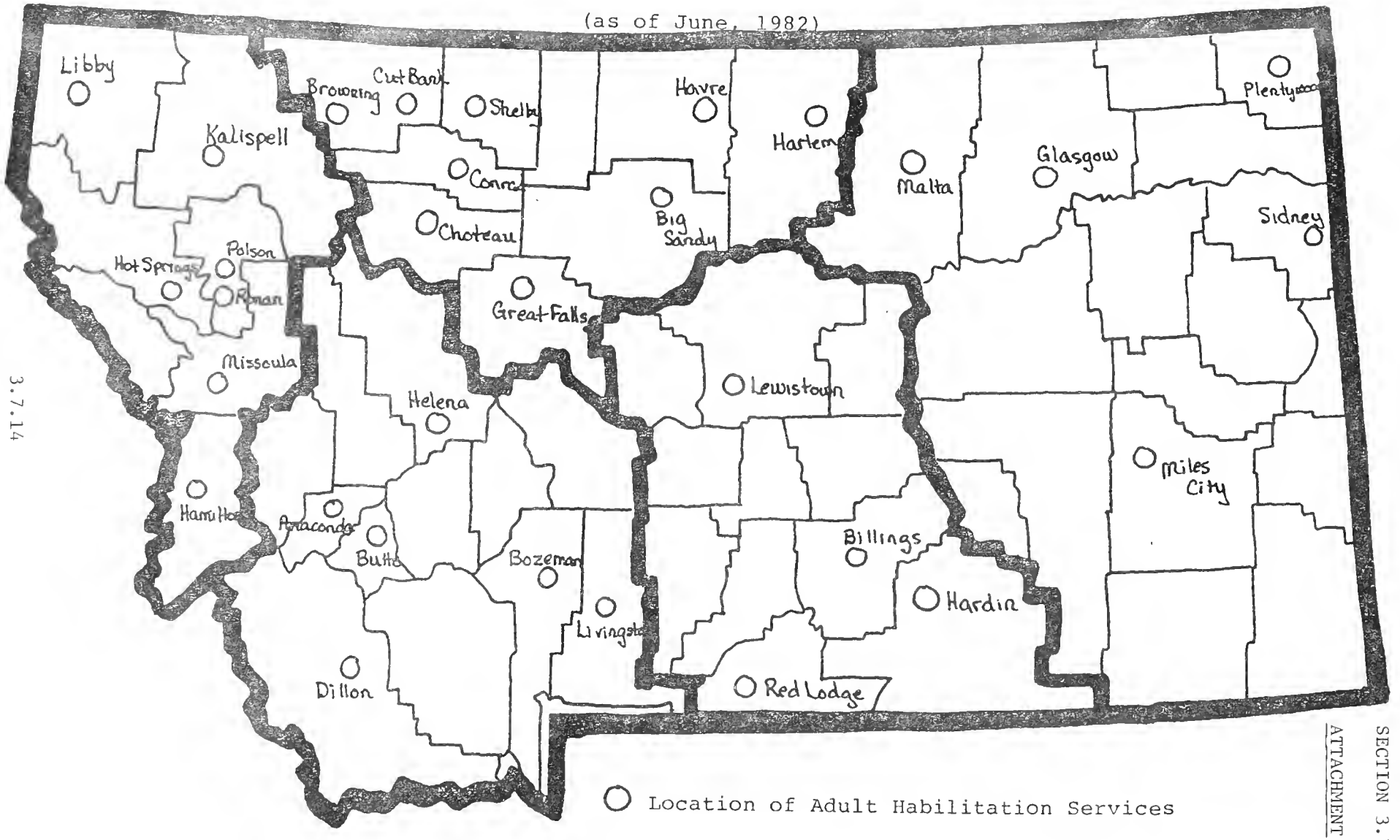


DEVELOPMENTAL DISABILITIES AREA MAP

1983-1984

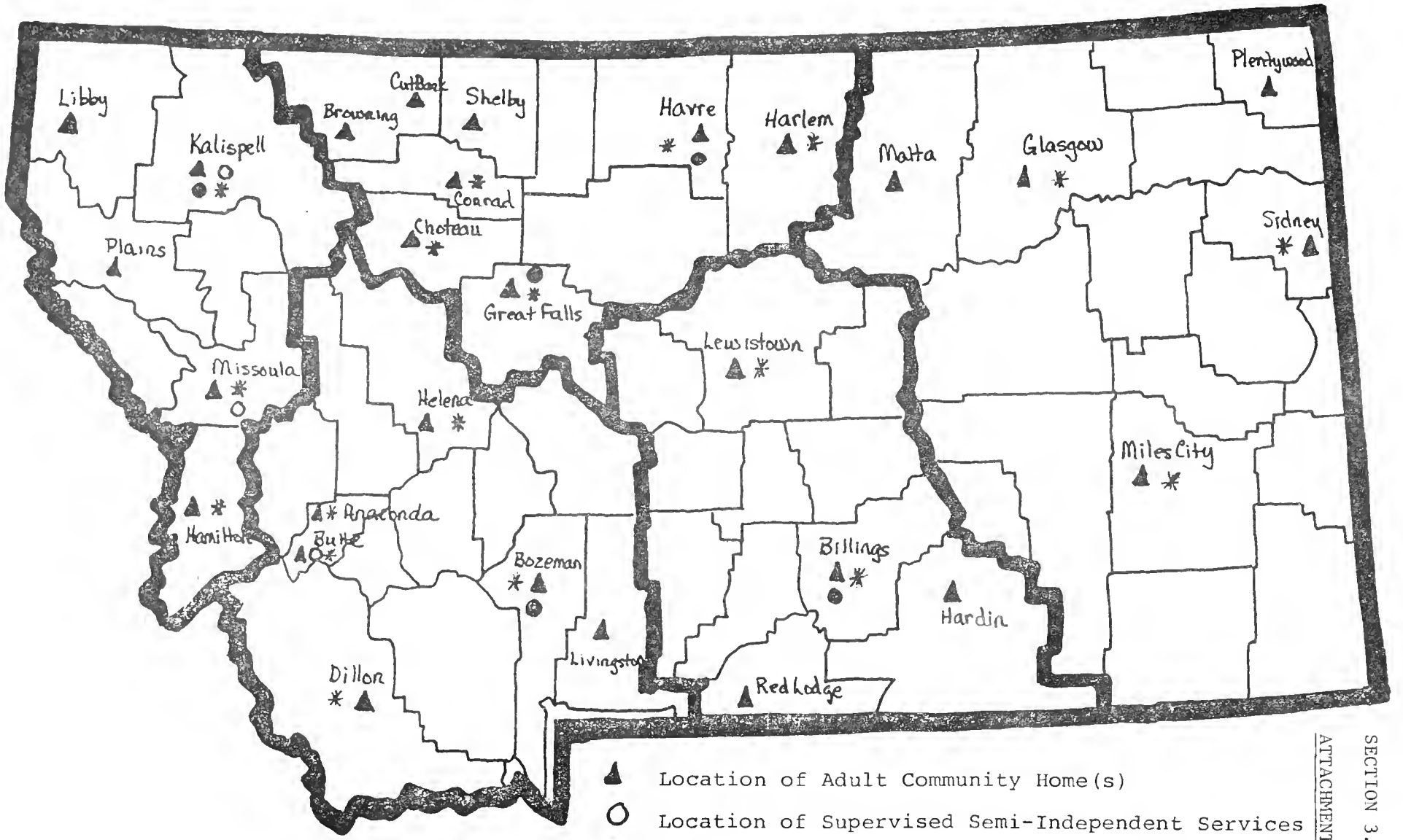
LOCATION OF ADULT HABILITATION SERVICES

(as of June, 1982)



LOCATIONS OF RESIDENTIAL SERVICES

(as of June, 1982)



▲ Location of Adult Community Home(s)

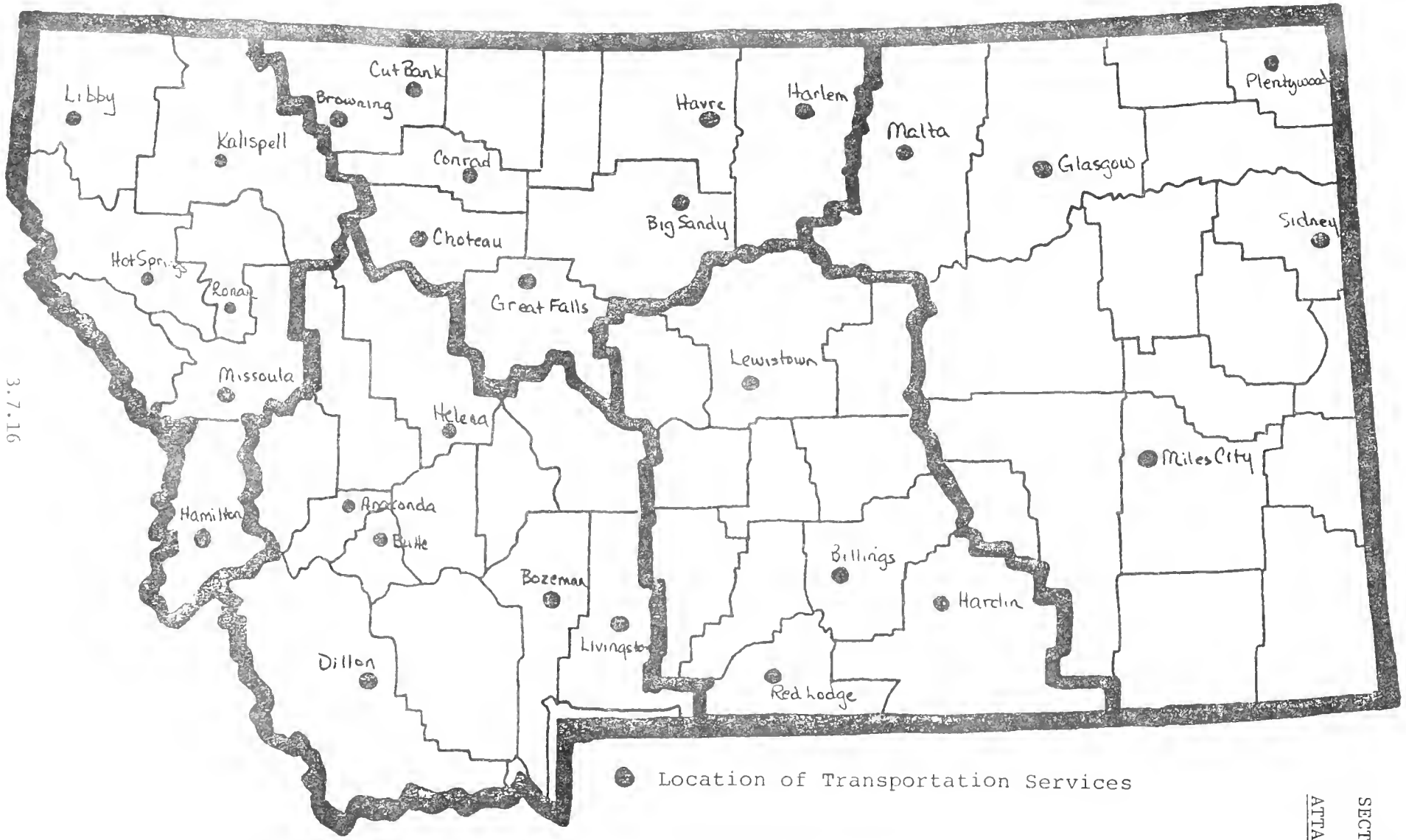
○ Location of Supervised Semi-Independent Services

● Location of Children's Community Home(s)

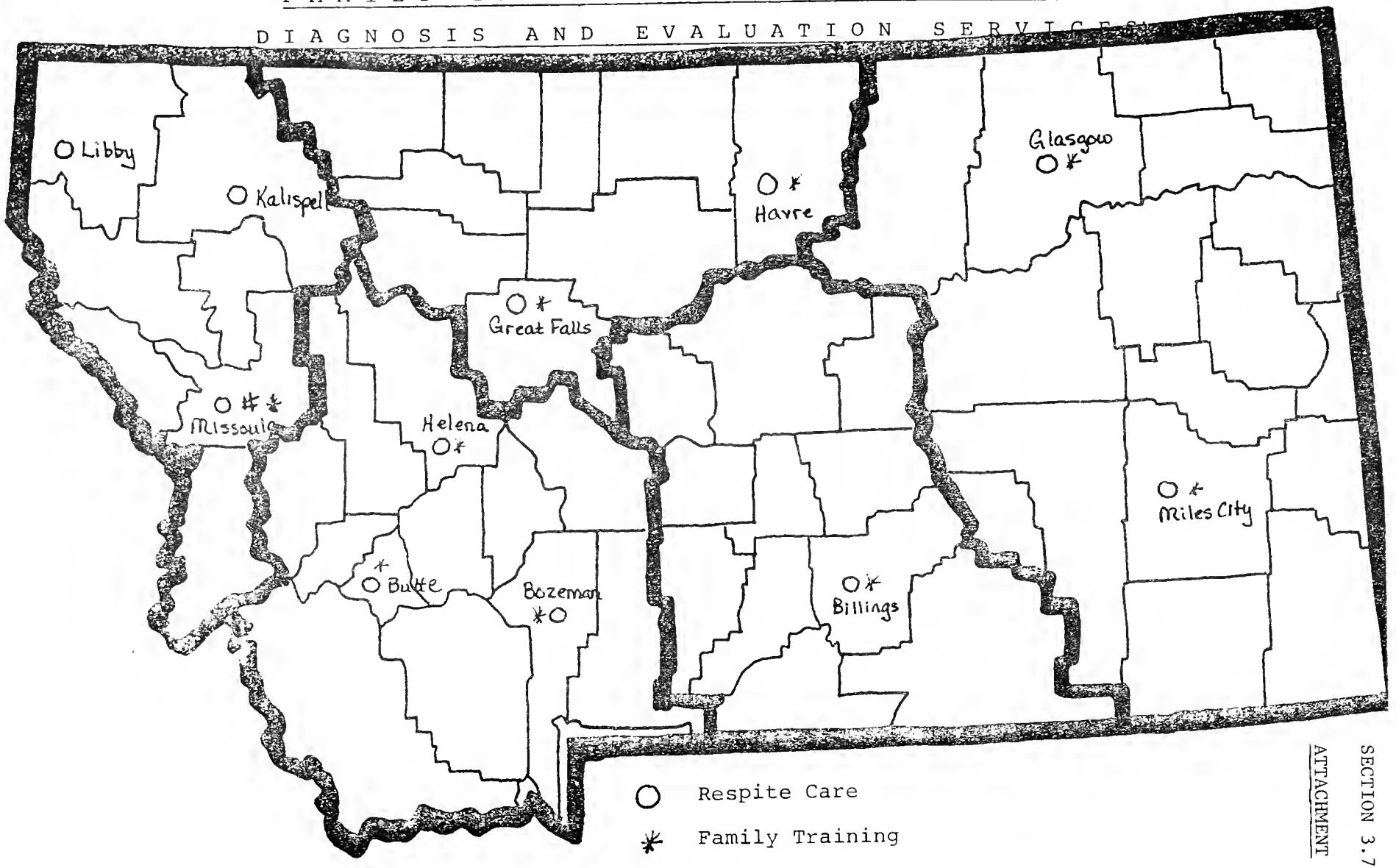
✱ Location of Semi-Independent Services

LOCATIONS OF TRANSPORTATION SERVICES

(as of June, 1982)



LOCATIONS OF FAMILY TRAINING AND SUPPORT AND DIAGNOSIS AND EVALUATION SERVICES*



* as of June, 1982

Sub-Chapter 1

Developmentally Disabled Program

46.8.101 PURPOSE OF THE DEVELOPMENTAL DISABILITIES DIVISION The purpose of the developmental disabilities division is to provide quality community-based services in the least restrictive environment which promotes the principle of normalization for citizens who are developmentally disabled. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-305 MCA; NEW, 1979 MAR p. 1708, Eff. 12/28/79.)

46.8.102 DEFINITIONS For purposes of this chapter, the following definitions apply:

(1) "Division" means the developmental disabilities division of the department of social and rehabilitation services.

(2) "Client" means a person with a developmental disability who is enrolled in a provider service program.

(3) "Provider" means any person or entity furnishing services to persons with developmental disabilities under a contractual agreement with the department through the developmental disabilities division.

(4) "Interdisciplinary team" means a group of persons that is drawn from or represents those professions, disciplines, or service areas that are relevant to identifying an individual's needs and designing a program to meet them, and that is responsible for evaluating the individual's needs, developing an individual habilitation plan to meet them, periodically reviewing the individual's response to the plan, and revising the plan accordingly.

(5) "Applicant" means a person who applies for services, but is not yet accepted into a service program. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-204 MCA; NEW, 1979 MAR p. 1708, Eff. 12/28/79.)

46.8.103 ELIGIBILITY REQUIREMENTS (1) Eligibility for diagnostic and evaluation services, family training and support services, and other services for developmentally disabled persons shall be determined as follows:

(a) Any person suspected of having a developmental disability is eligible for diagnostic and evaluation services. Eligibility will be determined by the diagnostic and evaluation service agency upon application for services to the agency.

(b) Family members are eligible for family training and support services if a child residing in the family unit is developmentally disabled under the terms of Section 53-20-202-(3) MCA, or is five (5) years of age or younger and is at risk for developmental delays. Eligibility for family training and support services will be determined by the provider upon application for services to the provider.

(c) Any person who is developmentally disabled under the terms of Section 53-20-202(3) MCA is eligible for such other services as may be provided by or funded through the division. Eligibility will be determined according to procedures established by the social service bureau, community services division of the department.

(2) An adverse decision regarding eligibility for services under this part may be appealed under the provisions of ARM 46.2.202, et. seq.

(3) Persons may contact the administrator, developmental disabilities division, p.o. box 4210, 111 Sanders, Helena, MT 59601 for information about available services and location of services. (History: Sec. 53-20-204 and Sec. 53-20-305 MCA; IMP, Sec. 53-20-205 and Sec. 53-20-209 MCA; NEW, 1979 MAR p. 1709, Eff. 12/28/79.)

46.8.104 EVALUATION SERVICES (1) The division shall provide for the evaluation of any person eligible for diagnostic and evaluation services either through services funded by the department or by referral to another agency.

(2) Within thirty (30) days of enrollment in a provider service program, with the exception of respite and transportation services, the provider shall perform a comprehensive skill assessment for each person enrolled in the program. Each assessment shall be reviewed semi-annually by the provider. Results of the assessment shall be provided to the client's individual habilitation planning team. (History: Sec. 53-20-203 MCA; IMP Sec. 53-20-203 MCA; NEW, 1979 MAR p. 1710, Eff. 12/28/79.)

46.8.105 INDIVIDUAL HABILITATION PLANS (1) An individual habilitation plan is a written plan of intervention and action developed by an interdisciplinary team of persons on the basis of a skill assessment and determination of the status and needs of a client. The individual habilitation plan ensures that the provision of services will be systematic and that interventions are designed to enhance the development of the client.

(2) Each client is entitled to an individual habilitation plan. Unless otherwise specified by provider agreement, the individual habilitation plan shall be developed within 30 calendar days of the client's entry into a service program and be formally reviewed and revised at intervals not to exceed six months from the initial or previously reviewed individual habilitation plan.

(3) Each individual habilitation plan shall be developed by an individual habilitation planning team. The individual habilitation planning team members are:

(a) the client and the client's advocate, if the client has an advocate, unless the participation of either is unob-

tainable and is so documented in writing. An advocate is a person who represents the interests and rights of a client as if they were the person's own, is not an employee of any agency directly providing services to the client and who is acknowledged by the client as his or her advocate at the time of the individual habilitation plan meeting. If both a client and an advocate participate on an individual habilitation planning team, the advocate's position must be consistent with the client's expressed interests;

(b) the client's parents, if legally responsible for the client, or the client's legal guardian, unless this participation is unobtainable and is so documented in writing;

(c) the clients case manager;

(d) one person who works directly with the client from each service program provided to the client;

(e) the professional person from the institution of origin if the client has not yet been formally discharged from that institution; and

(f) staff member of the division whenever possible.

(4) Advisory members of the individual habilitation planning team may include:

(a) any family member or relative; and

(b) psychologists, medical personnel and other consultants.

(5) Each individual habilitation plan shall include at least the following:

(a) the goals toward which the interventions outlined in the individual habilitation plan will be directed;

(b) the pertinent results of assessments, both formal and informal, which outline the client's strengths and behavior/skill deficits;

(c) specific objectives, stated separately and in behavioral terms, which specify single behavioral outcomes, and reflect the client's needs as identified by assessment data and the goals established for the client. Components of objectives are:

(i) a statement of the conditions or setting in which the behavior is to occur;

(ii) an objective, measurable description of the behavior; and

(iii) a statement of the acceptable level of performance.

(d) names of persons, and the agencies, programs or services they represent, who have been assigned responsibility for implementation of the objective;

(e) the date by which each person is to begin implementing programs for each objective assigned by the individual habilitation planning team;

(f) projected date by which the client is expected to have met each objective;

(g) documentation of the barriers or conditions responsible for each client need which will not be addressed or attempted to be met before the next individual habilitation planning meeting;

(h) a summary of the client's medical and dental status, including the physicians' names, dates and results of the client's most recent health examinations, a list of and rationale for any prescribed medications, current method of administration, and any medical goals and objectives relating to the client's medical status;

(i) administrative goals and objectives, including initiation and completion dates;

(j) names, program affiliations and signatures of each person accepting responsibility for a role, task or objective assigned to him or her by the individual habilitation planning team; and

(k) names and signatures of all persons who have participated in developing the individual habilitation plan (including the client, unless the client's unwillingness to participate is documented) which will verify participation, agreement with the individual habilitation plan, and acknowledgement of the confidential nature of the information presented and discussed.

(6) The individual habilitation planning team shall designate a member or members to review the individual habilitation plan and resulting individual program plans (written strategy for meeting an objective) on at least a monthly basis for implementation and continued appropriateness. This review shall document:

(a) progress data recorded in behavioral terms at least as often as the intervals designated by the individual habilitation planning team; and

(b) problems and changes in a client's status warranting review of the individual habilitation plan by the individual habilitation planning team. The review information will be sent to the case manager and other interested individual habilitation planning team members every month or as designated by the individual habilitation planning team.

(7) The individual habilitation planning team shall meet at least every six months to formally review the goals and objectives established at the previous individual habilitation planning meeting. In reviewing the previous individual habilitation plan, the individual habilitation planning team shall:

(a) review progress data which has been collected on the client's response to each objective and individual program plan assigned at the last individual habilitation plan;

(b) modify the goals and objectives as necessary and suggest changes in ongoing individual program plans;

(c) determine further services and programs that are

needed as a result of current assessments or assessment updates completed prior to the meeting; and

(d) consider the advisability of continued current service provision and alternative placements or services.

(8) The case manager, or other person, assigned by the individual habilitation planning team shall provide the individual habilitation plan to the client; to the client's family, when appropriate; and to each member of the individual habilitation planning team. The case manager or other designated person shall interpret the individual habilitation plan to the client.

(9) The duties of the case manager in the individual habilitation planning process are:

(a) to schedule individual habilitation planning meetings whenever individual habilitation plan revision is deemed necessary by any individual habilitation planning team member but at least every six months;

(b) to notify in writing (except for meetings called in emergency situations) all individual habilitation planning team members, parents, and any other appropriate persons of the date, time and place of the individual habilitation planning meetings at least two weeks prior to the scheduled individual habilitation planning meeting;

(c) to explain the purpose of, obtain input from, and otherwise prepare the client for upcoming individual habilitation planning meetings;

(d) to record the results of the individual habilitation planning meetings, interpret them to the client and disseminate copies to all individual habilitation team members within two weeks of the individual habilitation planning meeting; and

(e) to ensure that the individual habilitation planning team members assigned the tasks of monthly reviews document the reviews in the client's individual habilitation plan file;

(f) to inform team members of the requirements of confidentiality.

(10) The decision-making process for development of an individual habilitation plan shall be as follows:

(a) decisions shall be made by consensus of individual habilitation planning team members;

(b) if a consensus cannot be reached, the individual habilitation planning team shall adjourn for no more than five (5) working days, to allow time for a resolution of the conflict;

(c) at the next individual habilitation planning meeting, if a consensus still has not been reached, the unresolved issues shall be referred to the regional supervisor and the social worker supervisor III who shall meet within ten (10) working days to jointly make a decision. Individual habilitation planning team members may attend to document the differing points of view;

(d) if the regional supervisor and the social worker supervisor III cannot reach a decision, or if any individual habilitation planning team member is dissatisfied with the decision, an appeal to the division administrator and social services bureau chief may be made who shall meet within ten (10) working days to jointly make a decision;

(e) further appeal may be made to the director of the department, whose decision shall be final.

(11) At each individual habilitation planning team meeting, the case manager shall review the requirements of confidentiality. Each non-member must sign a statement to the effect that he or she is aware of the confidential nature of the client information and will treat such information in accordance with the department's policy on confidentiality. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-203 MCA; NEW, 1979 MAR p. 1715, Eff. 12/28/79.)

46.8.106 CONFIDENTIALITY OF INFORMATION (1) Confidential information, for purposes of this chapter, includes the following information about any applicant or client:

(a) name and address;

(b) the amount or type of services provided;

(c) information related to the social and economic conditions or circumstances;

(d) agency evaluation of information;

(e) medical data, including diagnosis, treatment, and past history of disease or disability;

(f) educational, training, habilitation or any similar data;

(g) any of the above information pertaining to the immediate family members.

(2) The department and the provider shall not disclose confidential information concerning any applicant or client except under the following circumstances:

(a) Information about an applicant or client may be released to department staff and providers who assist in or participate in the provision of services to the applicant or client.

(b) Information, as specified, may be disclosed upon the written consent of:

(i) the applicant or client if he is a legally competent adult; or

(ii) the client's parents, if legally responsible for the applicant or client, or the legal guardian of the applicant or client.

(c) Information may be disclosed if it is in summary, statistical, or any other form which does not identify and cannot be used to identify any applicant or client.

(d) Information may be disclosed pursuant to a court order issued by a court of competent jurisdiction, to the

extent required by the court order.

(e) Information may be disclosed to the extent required to take immediate life-saving measures. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-204 MCA; NEW, 1979 MAR p. 1710, Eff. 12/28/79.)

46.8.107 CLIENT GRIEVANCE PROCEDURE (1) A provider shall maintain a written grievance procedure by which a client may file a complaint. A current copy of such procedure must be approved by the department.

(2) Upon entry into a program and at least every six months thereafter, a client must be advised by the provider of the right to present grievances. The provider shall assist clients, as may be necessary, in utilizing the grievance procedure.

(3) If the outcome of the grievance procedure is adverse to a client, the provider shall notify the person of his or her right to appeal to the department under the department's fair hearing procedure. (History: Sec. 53-20-204 MCA; IMP Sec. 53-20-205 MCA; NEW, 1979 MAR p. 1711, Eff. 12/28/79.)

46.8.108 SERVICE PROGRAM FUNDING (1) All developmental disabilities service contracts funded through the division which exceed $10,000 in amount shall be formally advertised by the division. Any person or entity who intends to request funds for the provision of services may respond to the formal advertisement or may at any time write a letter of intent to the division, 111 Sanders, p. o. box 4210, Helena, MT 59601. The letter of intent shall include:

(a) type of service to be provided;

(b) population to be served;

(c) geographical area to be served; and

(d) service initiation date.

(2) Within thirty (30) days of receipt of a letter of intent the division will place the applicant's name on a "Request for Service Funding List" and so notify the applicant. Persons or entities on the list will be notified when funds are available for service funding in the geographical area and service type designated.

(3) Completion of an application form or application form update and a project proposal will be required prior to the selection of projects. The selection process may include a regional review.

(4) No project funds will be awarded without a formal agreement between provider and department. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-205 MCA; NEW 1979 MAR p. 1711, Eff. 12/28/79.)

46.8.109 CERTIFICATION OF PERSONS ASSISTING IN THE ADMINISTRATION OF MEDICATION (1) This rule establishes procedures under which an employee or an agent of a provider

may assist and supervise a client in taking medication. Such assistance and supervision may only be given where a medication which is normally self-administered has been prescribed for a client and where the physician who prescribed the medication also prescribed assistance or supervision in the administration of the medication.

(2) For the purposes of this rule, the following definitions apply:

(a) "assistance" means providing any degree of support or aid to a client who independently performs at least one component of medication-taking behavior; and

(b) "supervision" means critically observing and directing a client engaging in medication-taking behavior.

(3) No agent or employee of a provider may assist or supervise in the administration of medication to clients unless certified by the department as herein provided unless otherwise authorized by law to provide such assistance or supervision. Every provider shall maintain a current list of provider employees and agents certified to administer medication on file with the division.

(4) Certification to provide such assistance will be determined by the department upon written application to the Developmental Disabilities Division, Department of Social and Rehabilitation Services, P. O. Box 4210, Helena, MT 59601. To be certified, an employee or agent of a provider must demonstrate knowledge of epilepsies and of use and side effects of medications by achieving a score of at least 90% on a comprehensive test administered by the department.

(5) Any provider may receive, free of charge, an instructional and reference aid entitled epilepsies and medications individualized instruction manual, which shall have been approved by the board of nursing.

(6) The department will administer the comprehensive test to a qualified applicant within 30 days of receipt of a written application for certification. Notice of certification or noncertification will be mailed within ten days of the date of testing. The notice will designate an effective date and an expiration date for the certification. Certification will in no event be longer than for a period of two years.

(7) Any assistance provided under this rule which occurs after the client has been enrolled in the program for 30 days and which must be administered for a longer period than ten consecutive days must be the subject of a written individual habilitation plan. An individual medication plan must be prepared which describes a program to train the client to self-administer the medication and must specify at least:

(a) the target medication-taking behavior;

(b) the conditions (e.g., times and places) in which such behavior should occur;

(c) the conditions (e.g., times and places) in which such behavior will be trained;

(d) criteria for completion of the individual program plan in accordance with section (9) herein;

(e) written strategies for training the target behavior;

(f) a data recording system which accounts for each prescribed medication dosage, and;

(g) a data recording system which specifies progress or lack of progress toward the target behavior on a daily basis.

(8) Every instance of assistance or supervision provided under this rule must be recorded and must include at least the name of the person who receives medication, the name of the person who assists or supervises the taking of medication, the date and time the medication was taken, and the type of medication taken.

(9) A client is considered to be capable of self-administering medication when it has been documented that the client has self-administered all (100%) of prescribed medication dosages for a consecutive 30 day period.

(10)(a) The department may revoke certification by notifying the certified person of the reason for revocation in writing at least ten days prior to the effective date of revocation. The certified person may request, in writing, within the ten days prior to revocation, a hearing from the division administrator, who will issue a decision no later than 30 days from the date the request for hearing was received. When a request for a hearing is made, the revocation will not be effective until the division administrator's decision is made.

(b) The department may, for cause, suspend a certified person's right to assist or supervise in the administration of medication for a period no longer than 15 days, after which the suspension must be removed or notice of revocation issued. If notice of revocation is issued, suspension may continue until the effective date of revocation or until the division administrator's decision is made. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-204(2); NEW, 1980 MAR, p. 1803, Eff. 6/27/80.)

Sub-Chapters 2 and 3 Reserved

Sub-Chapter 4

Regional Councils

46.8.401 REGIONAL COUNCILS (1) The director of the department shall recognize a petition by a citizens' organization for a developmental disabilities regional council under the procedures set forth herein. The petition shall be signed by a majority of the proposed members and shall provide:

(a) that the proposed council has not more than twenty (20) members;

(b) the names and addresses of each proposed council member;

(c) that the citizens' organization is broadly representative of the region and at least one-third (1/3) of the council's members are consumers or representative of consumers or consumer organizations in the discipline of developmental disabilities;

(d) that no proposed members are employees of the department of social and rehabilitation services or employees of a provider service program funded wholly or in part through the developmental disabilities division;

(e) that the citizens' organization held at least three (3) public meetings in different areas of the region and that the public was encouraged to attend and participate in the formation of a regional council;

(f) that the public was given adequate notice of the meetings by means of local news media such as radio, newspapers and television throughout the region;

(g) that the organization has compiled by-laws for the proposed council; and

(h) that a recognized regional council for developmental disabilities does not exist for that region.

(2) A citizens' organization shall submit its petition to the director, department of social and rehabilitation services, p.o. box 4210, Helena, MT 59601. The director shall notify the citizens' organization, in writing, no later than thirty (30) days after receipt of the petition whether the citizens' organization is approved as a regional council for developmental disabilities.

(3) Citizens' organizations approved by the department as regional councils prior to December 1, 1979, shall be treated as if approved in accordance with the provisions of this section.

(4) Regional councils shall file with the director of the department current copies of council by-laws and council membership lists no later than October 1 of each year. The council membership list shall include sufficient information about council members to verify that the council is constituted in accordance with the laws of the state and this chapter

provided, however, that any person who is a member of a regional council on January 1, 1980, may complete his or her term. Notice of approval or non-approval of by-laws and membership will be sent by the director no later than November 1. Any regional council not in compliance with the provisions of this chapter will be provided a period of time, as determined by the director, which will be no less than thirty (30) days to correct such situation.

(5) Regional council by-laws. A regional council shall adopt by-laws which shall set forth:

(a) a stated purpose;

(b) the council duties, consistent with law;

(c) that membership on the council, except for vacancies occurring for any reason during a member's term, will be determined by election held at a public meeting which has been advertised in the news media throughout the region for a set number of days, and for which a set number of day's notice has been given; and which persons present are eligible to vote in such elections;

(d) that no members are employees of social and rehabilitation services or employees of a provider service program funded wholly or in part through the developmental disabilities division;

(e) provisions which:

(i) identify potential conflict of interest situations for council members;

(ii) detail the manner in which such conflicts will be handled, which provisions must, at a minimum, restrict a member from evaluating a service program in which the member has a direct interest or voting on any matter, the outcome of which will directly affect a member's interest; and

(iii) provide for the monitoring of such conflict of interest provisions.

(f) provisions governing terms for members;

(g) provisions for filling vacancies created on the council during members' regular terms;

(h) provisions for electing officers for the council, for terms of office for officers, and for the filling of vacancies created during terms of office;

(i) that a quorum shall be at least a majority of the voting membership of the council, including alternates present to represent absent members;

(j) that the council will conduct regular meetings at least once during each calendar quarter, that records shall be kept of activities of the council and the means by which the public has access to the records;

(k) that if a committee is created, the purpose and function of that committee; and

(l) provisions for amending the by-laws.

(6) Regional councils shall:

(a) advise the department, other state agencies, councils, local governments, and private organizations on programs for services to the developmentally disabled within the region;

(b) make an annual written review and evaluation of needs within the region, including a list of priorities according to the findings of the review, and provide a copy of the review to the department and the developmental disabilities planning and advisory council by December 1 of each year;

(c) develop an annual plan for a system of community-based services for the developmentally disabled within the region and provide a copy of the plan to the department and the planning and advisory council by March 1 of each year preceding the federal fiscal year to which the plan applies;

(d) make an annual written review and evaluation of services presently provided within the region and provide a copy of the evaluation to the department and the planning and advisory council by May 1 of each year;

(e) provide two names for regional representatives to the planning and advisory council as requested by the council; and

(f) inform the department of changes in officers, members and alternates of the regional council, or of changes in the by-laws.

(7) The department shall employ a regional supervisor for each region to provide technical and administrative assistance to the regional council in:

(a) preparing a review and evaluation of needs and services;

(b) advising the department on programs for services;

(c) developing a plan for the developmentally disabled within the region, and to provide such additional assistance as may be assigned by the division administrator. (History: Sec. 53-20-207 MCA; IMP, Sec. 53-20-203 and 53-20-207 MCA; NEW, 1979 MAR p. 1721, Eff. 12/28/79.)

Sub-Chapter 5

Planning and Advisory Councils

46.8.501 DIVISION QUARTERLY REPORT (1) The department shall provide to the developmental disabilities planning and advisory council a written quarterly report within 45 days following the last day of each fiscal quarter. This report shall contain:

(a) total developmental disabilities division budget;
(b) administrative operating budget;
(c) training budget;
(d) service contract and grant budget;
(e) total number of individuals receiving services;

(f) types and number of services;
(g) number of clients in each type of service;
(h) budget per service;
(i) source of funding per type of service;
(j) service goals and objectives; and
(k) service priorities.

(2) Copies of quarterly reports can be obtained upon request to the developmental disabilities division, p. o. box 4210, 111 Sanders, Helena, MT 59601. (History: Sec. 53-20-204; IMP, Sec. 53-20-203; NEW, 1979 MAR p. 1712, Eff. 12/28/79.)

46.8.502 PREPARATION OF MONTANA DEVELOPMENTAL DISABILITIES STATE PLAN (1) The department and the developmental disabilities planning and advisory council shall jointly prepare an annual comprehensive state plan for the initiation and maintenance of developmental disabilities services in the state.

(2) No later than March 30 preceding the federal fiscal year to which the state plan applies, the planning and advisory council will provide to the department information gathered from advisory organizations and other public and private agencies relative to the following matters:

(a) state goals and objectives for developmental disabilities services;
(b) service needs and service gaps;
(c) service priorities; and
(d) interagency responsibilities for service delivery.

(3) The state plan must be approved by the council and by the director of the department. (History: Sec. 53-20-204 MCA; IMP, Sec. 53-20-203 and 53-20-206; NEW, 1979 MAR p. 1712, Eff. 12/28/79.)

Sub-Chapter 6 Reserved

Sub-Chapter 7

Certification of Professional Persons

46.8.701 GENERAL (1) The department of social and rehabilitation services and the department of institutions shall jointly certify developmental disabilities professional persons and mental health professional persons.

(2) Definitions used for certification of professional persons in the areas of mental health and developmental disabilities are:

(a) "SRS means the department of social and rehabilitation services.
(b) "Institutions" means the department of institutions.
(c) "Mental health professional person" is a person

trained in the field of mental health and certified by SRS and institutions.

(d) "Developmental disabilities professional person" is a person trained in the field of developmental disabilities and certified by SRS and institutions.

(e) "Certification committee" means the committee with delegated authority to certify mental health professional persons and developmental disabilities professional persons.

(f) "Applicant" means a person seeking certification as a professional person.

(g) "Accredited program" means a program recognized and accredited by national accrediting agencies for academic and professional preparation programs.

(h) "Year of experience" means one year of full-time employment following receipt of the requisite minimum academic credential, or as otherwise provided for herein.

(3) Professional persons shall be certified for the following purposes:

(a) to recommend to the district court the most appropriate habilitation plan or treatment plan for an individual who is or may be found to be developmentally disabled or mentally ill based upon his evaluation of the individual when a commitment to a residential facility is being sought for that individual; and

(b) to be responsible for assuming the development and implementation of an assigned resident's individual habilitation plan or treatment plan when employed within a residential facility for that purpose as specified in Section 53-20-148 MCA.

(4) These rules shall not supercede or replace any rules or laws regarding the licensure of any professional provided for by law or other rules. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

46.8.702 CERTIFICATION COMMITTEE (1) The certification committee shall:

(a) review all applications requesting certification as professional persons;

(b) certify applicants as professional persons in accord with these rules; and

(c) perform other duties set forth by these rules or assigned to the certification committee by the directors of SRS and institutions.

(2) The certification committee shall be composed of the following membership:

(a) a person appointed by the governor who shall serve as chairperson of the certification committee; and

(b) the directors of SRS and institutions shall each appoint two persons representative of professionals eligible for certification.

(3) Members of the certification committee shall serve at the convenience of the appointing director. Meetings of the certification committee shall be called by the chairperson.

(4) The certification process as a professional person shall include:

(a) submission of application forms by applicant;

(b) a review within ninety days by certification committee of completed application forms to determine qualification of applicant for certification;

(c) an issuance of provisional or permanent certification by the certification committee or denial of the application;

(d) a notification of the disposition to the applicant within 30 days of the disposition of the application;

(e) permanent certifications are subject to periodic review. Provisional certification can be renewed by the regular application process set out in this rule. The certification committee may issue provisional certification that limits the professional person to providing specific services or limits the conditions under which the professional person can provide services, or the time period such certification shall be effective, or any combination thereof; and

(f) the certification committee may revoke certification by notifying the certified professional person in writing of the reasons for revocation at least 10 days prior to the effective date of revocation. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

46.8.703 RIGHT TO APPEAL (1) Any action of the certification committee concerning certification denial or revocation may be appealed to the directors of SRS and institutions. If the aggrieved party is not satisfied with the action of the directors, he may request to have his grievance heard by a professional persons certification grievance committee. The professional persons certification grievance committee shall be composed of four members who will be representative of professional groups, with two members appointed by the director of SRS and two members appointed by the director of institutions. All findings and actions of the professional persons certification grievance committee shall be binding on the certification committee.

(2) The notice of appeal shall be directed to the director of SRS or institutions.

(3) The appeal shall be in writing setting forth the nature of the grievance and arguments supporting the grievance and actions desired. The appealing party may also present oral argument before the grievance committee.

(4) All parties to the appeal shall be notified in

writing ten days prior to the hearing of the grievance committee. The written notice shall contain as a minimum, the date, day, time and location of the hearing.

(5) The guidelines for conducting the hearing shall be established by the grievance committee.

(6) If any party to the appeal is dissatisfied with the decision of the grievance committee, he may appeal to the appropriate district court of jurisdiction. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

46.8.704 CERTIFICATION OF PROFESSIONAL PERSONS, QUALIFICATIONS (1) Mental health professionals:

(a) Applicants possessing a license from the Montana department of professional and occupational licensing, board of psychologists, as a licensed psychologist, shall be eligible for certification as a professional person. Evidence of appropriate experience may be required at the discretion of the committee. For psychologists without such a license, the applicants shall possess a master's degree in psychology from an accredited program. Academic training shall be in a clinical field of psychology that directly relates to psychopathology. Applicants in the field of psychology shall have at least one year of experience in delivering professional services to clients in a mental health setting.

(b) In the field of guidance and counseling, applicants shall possess a master's degree in guidance and counseling from an accredited program and shall have at least one year of experience in delivering services to clients in a mental health setting.

(c) In the field of nursing, an applicant shall be a registered nurse, licensed under Montana law, preferably with a bachelor's degree in nursing and must have at least three years of nursing experience in providing services to clients in a mental health setting.

(d) In the field of social work, applicants shall possess a master's degree from an accredited program that provides training in the treatment of mental disorders and shall have at least one year of experience in delivering professional services to clients in a mental health setting. Membership in academy of certified social workers may be substituted for above education and experience.

(2) Developmental disability professionals:

(a) Applicants possessing a license from the Montana department of professional and occupational licensing, board of psychologists, as a licensed psychologist shall be eligible for certification as a professional person. Evidence of appropriate experience may be requested at the discretion of the committee. For psychologists without a license, applicants shall possess the following combination of experience and education:

(i) a doctoral degree from an accredited program and evidence of appropriate experience;

(ii) a master's degree with one year of experience in a developmental disability program setting; and

(iii) a bachelor's degree with three years of experience under the direct supervision of a professional person or a person eligible for certification.

(b) Applicants possessing a membership in the academy of certified social workers shall be eligible for certification as a professional person. Evidence of appropriate experience may be requested at the discretion of the committee. Applicants without an ACSW membership shall possess the following combination of experience and education:

(i) a master's degree with one year of experience in a developmental disability setting; and

(ii) a bachelor's degree with three years of experience under the direct supervision of a professional person eligible for certification.

(c) In the field of special education, applicants shall possess the following combination of experience and education:

(i) a doctoral degree from an accredited program and evidence of appropriate experience;

(ii) a master's degree from an accredited program with one year of experience in a developmental disability program setting; and

(iii) a bachelor's degree with three years of experience under the direct supervision of a professional person or a person eligible for certification.

(d) In the fields of rehabilitation, physical therapy and occupational therapy, an applicant must have a bachelor's degree and at least three years of experience under the direct supervision of a professional person and involved in the planning and development of habilitation plans. Applicants must also provide as a part of their application a description of their expected duties and responsibilities as a developmental disabilities professional and a statement of need for certification from their supervisor.

(3) The certification committee may substitute experience for educational qualifications as determined by the committee to be appropriate or provided for within these regulations.

(4) The certification committee retains the right to determine the appropriateness of any experience; i.e., training, workshops, etc., for certification purposes. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

TRAINING RESOURCE & INFORMATION CENTER

POLICIES

P.O. Box 4210, Helena, Montana 59604 (406) 449--5647

WHO MAY USE TRIC SERVICES?

Anyone who provides service to developmentally disabled citizens of Montana. TRIC gives priority to service providers funded by the Developmental Disabilities Division of the Department of Social and Rehabilitation Services (SRS/DDD). Other users are served as a courtesy.

HOW DO I REGISTER FOR TRIC SERVICES?

To register, till out a TRIC User Card. Return it to TRIC. Whenever your address or program affiliation changes, please let us know.

HOW DO I BORROW MATERIALS?

Drop into the library to browse and check out materials directly. These are loaned for two weeks. If it's more convenient, call or write your request. Materials delivered through the mail are loaned for three weeks. If you need more time, renew your loan by phone, letter, or personal contact. If you have any overdue materials, send them back before requesting others. We can't check out more materials until you return any that are overdue.

Although there's no set limit on the number of materials checked out to any one user at a given time, the TRIC staff may limit check-outs as they see fit (e.g., if our entire stock of materials on a topic would be depleted).

WHAT'S THE POLICY ON OVERDUE MATERIALS?

Before the due date, call TRIC for an extension. One will be granted if no one is on the reserve list for the particular material. Be sure to write the new due date on the date due slip; it helps us reshelve the material when it's returned.

If we don't hear from you, one reminder will be sent immediately after a material becomes overdue. If the overdue material is not received at TRIC within five working days of the reminder date, the user will be billed

WHAT IF A MATERIAL IS DAMAGED, LOST, OR STOLEN WHEN CHECKED OUT TO ME?

A material becomes the responsibility of the borrower as soon as it leaves TRIC. We will bill you for replacement costs if you can't return a material.

To protect yourself if someone else wants to use a material, call TRIC first. Someone else may be waiting for the material. If not, we'll put the new borrower's name on the check-out card, placing the responsibility for returning the material on the new user.

WHAT IF YOU DON'T HAVE THE MATERIAL I NEED?

TRIC staff will gladly search for what you need from other sources. If the requested material is considered a valuable addition to the library, it will be purchased or developed by TRIC. Make these special requests in person, by phone, or through the mail.

ARE THERE ANY SPECIAL POLICIES ON FILM CHECK-OUT?

Yes. Service providers funded by SRS/DDD pay only return postage and shipping insurance on borrowed films. All other users pay postage and shipping insurance both to and from TRIC. All films must be insured in transit for $250. If a film is damaged or runs roughly through the projector, please attach a note to the outside so that we can repair it.

WHAT ABOUT EQUIPMENT LOANS?

Only service providers funded by SRS/DDD are eligible for equipment check-out. To check out TRIC equipment, users sign the TRIC Equipment User Responsibility Form. Equipment must be insured for replacement value in transit. Equipment is loaned during the work week but must be back at TRIC over the weekends. If equipment is lost, damaged, or stolen, the borrower will be billed $250 for the deductible state insurance. If the equipment weights more than five pounds the user pays postage and shipping insurance both to and from TRIC.

We aim to help you acquire materials to make your job easier.

Your cooperation and respect for TRIC's materials will, in turn, help us serve you better.

SECTION 3.8

SCOPE OF SERVICES

DEVELOPMENTAL DISABILITIES/MONTANA ADVOCACY PROGRAM

DEVELOPMENTAL DISABILITIES/MONTANA ADVOCACY PROGRAM

(DD/MAP, INC.)

1. Profile of Current Services

DD/MAP provides advocacy services to developmentally disabled persons who are having difficulty obtaining appropriate services and/or exercising their rights. We provide services statewide. Eligibility criteria are:

A. Must be developmentally disabled by federal definition;

B. Must have problem or need that is rights related; and

C. Rights related problem must also be specifically due to the existence of a disability. Persons of all ages and disabilities within the federal definition who fall within the above criteria are eligible for our advocacy services.

Services include: information and referral; information only; consultation; negotiation; direct non-legal intervention; direct legal intervention; and training.

Point of contact is through the office in Helena. It is a simple matter of calling or writing the office, and a painless intake form is filled out and the work begins. If a client or parent of a minor calls us directly, we will become immediately involved. If someone calls on behalf of a DD person, we will request that they ask the client or parent to call us (collect) or that they obtain specific permission from the client or parent to give us their name and number so we can contact them directly. Confidentiality is highly honored by our agency, and we obtain Release of Information from the client prior to contact with other agencies/persons.

The budget for FY 1983 is $66,000: Protection and Advocacy formula - $50,000; DDPAC - $14,000; Carryover from FY 1982 - $2.000. We can only count on the minimum allotment of $50,000 as identified in 45 CFR Section 1385.8 each year.

DD/MAP serves people who are developmentally disabled via the federal definition. We determine this through our intake process. This has not proved to be a difficult take in most situations. The difficulty occurs when someone is Federal DD eligible but not State DD eligible. No agency has accepted responsibility for those eligible under Federal definition, so we must mix-match-push-pull. This has proven to be most frustrating.

FUNCTIONAL LIMITATION		
Y	N	
		Before 22
		Continued Indef.
		SERVICES
		Indiv. Planned
		Extend Duration
		LIMITATIONS (3)
		SELF CARE
		Language
		Learning
		Mobility
		Self-direct
		Indep. Living
		Econ. Sufficiency
		Infant at Risk
		Related to Disability?

Currently, DD/MAP has the equivalent of 2.45 staff. This includes: 1 full-time Administrator/Advocate; 1 full-time Outreach Advocate; 1 part-time Secretary (.15); and 1 part-time staff attorney (.30).

We are a non-profit corporation with a seven (7) member Board of Directors. Members come from all parts of the State and represent the following: 2 disabled persons; 4 parents (3 children, 1 adult); and 1 attorney. The Board meets at least quarterly and provides guidance and policy for staff to follow in their daily work.

2. Generic Services Accessed by Agency and Clients

DD/MAP utilizes any generic service possible in obtaining the optimum benefit for our clients. For instance, we have used: Legal Services; Public Defenders; Local Advocacy Programs; Social Services; DD Division and Local Providers; Office of Public Instruction; Community Mental Health Centers for Evaluation and Treatment; Private Therapists; Private Evaluation Centers; Probation/Parole Personnel; Private Attorneys; and Family and Friends.

We support the involvement of any generic services possible and appropriate with our clients, and our clients obtain services from a multitude of generic services. See list in above paragraph. Since our client population is so fluid and their needs so very varied, these services do not remain static.

3. Implementation Schedules and Responsible Agencies

Service priorities are determined by a process which involves recommendations by staff to the Board of Directors. So far, it has been the consensus that staff concentrate its energies on:

A. Providing individual advocacy services;

B. Providing systems advocacy;

C. Offering training to a variety of audiences; and

D. Providing information through publication of Legal Rights Manual and regular newsletter.

Services provided under "A" include information and referral, information only, consultation, negotiation, on-site non-legal intervention, and legal intervention. This is top priority and always has been.

Services provided under "B" include input to various State agencies that develop and provide services to DD persons. This is one area that might, in light of increasing need and diminishing resources, change to include more staff energy.

Services provided under "C" currently include participation with someone elses training, i.e., participation in yearly DD Conference with PLANS to offer certain training modules in the remainder of FY 1983 and the first part of FY 1984. We will continue participation in existing seminars.

Services provided under "D" include PLANS. We plan to publish and distribute a Legal Rights Manual by the end of June, 1983, and we plan to offer a newsletter starting July, 1983.

4. Profile of Proposed or Tentative Agency Expansion Plans

We currently have a pending grant application to Utah State University which would provide in-service training to DD/MAP Staff regarding Indian Law and the service system on the various Reservations within Montana, and in-service training by DD/MAP TO Reservation Services and Parents.

Expansion now includes increased training to a variety of audiences, availability of a Legal Rights Manual, and publication of a newsletter.

We would like to expand our efforts somewhat in the area of systems advocacy through participation in "task force-like" efforts regarding development of service alternatives for unserved populations; i.e., DD offender and persons with brain-stem injuries. There are no specific timelines or plans at this time.

Finally, we would like to become more particularly involved with the minority populations, especially the Native American population, centered on Reservations.

5. Summary of Service Population

We do not keep separate data according to State or Federal definition. All persons we serve are developmentally disabled according to Federal definition. We do keep track of categorical disability, but not for purposes of eligibility. Latest Statistical Report in Attachments.

6. Service Gaps

Many of the service gaps affect a relatively small number of individuals, which sometimes creates an even more difficult situation. For instance, if we knew there were fifty (50) DD offenders, there would be an outcry, perhaps; since we do not know how many, and perhaps less than ten (10), it is difficult to focus the system's attention on such a small number. As advocates, we have to continuously "badger" the system about these unserved people, and the significance of their problem. From our perspective, they include:

DD Offenders - Usually DD persons who fall into this category are on the upper level of categorical definition, but are truly dysfunctional. There are no programs geared to serve this population - and so far none interested or committed sufficiently to develop services. There are model programs in other parts of the country from which to draw. Perhaps inter-departmental cooperation would get us nearer to a resolution.

Individuals with brain stem injuries due to traumatic accidents, many happening after age eighteen (18), some after age twenty-two (22). There is an inability and unwillingness on the part of the system to serve this population currently. They are truly caught in-between the cracks; for most either do not fall within the State definition of DD for services or do not appropriately fit within the scope of services as they now exist; many are not eligible for vocational rehabilitation, but do not qualify for any other vocational/-day program service; many require constant supervision for safety purposes; many have particular nuances as a result of their injury that are unique to them, and seemingly unique to the service system. We need a Task Force approach to this problem, and again, commitment of various departments and divisions to work together. The interest is growing.

Physically disabled persons who require a certain level of skilled care, but not necessarily nursing care, who are placed in nursing homes for a lack of other alternatives; many residential facilities are not physically accessible, and lack some of the required paramedical abilities to deal with certain physical limitations.

Guardians (full or limited) for persons unable to provide informed consent; individuals are hard to find who are willing to fulfill this role, and the State is often reluctant to do so. We need:

A. Non-profit Corporations which provide this particular service; or

B. Systems change within counties and the State so that this service will be provided when necessary.

Dual-diagnosed clients; i.e., mentally retarded and mentally ill; mentally retarded and chemically dependent; severely physically disabled and mentally ill. Again, we need systems approach and cross departmental interest and attention. The numbers are small, but that does not diminish the individual need for critical services.

Native American population, especially on Reservation: More needs to be known about availability/desirability of services to DD persons living on the Reservations. Money for outreach to DD/MAP would begin to deal with this problem - and we would work closely with Reservation resources.

PLUS, we always need more of the same.....

7. Program Evaluation Procedures and/or Plans for New or Additional Evaluation Programs

Personnel: Executive Director is evaluated by Board President and other staff are evaluated by Executive Director. The agency has Personnel Policies which outline the process.

Program: We will begin submitting Annual Reports (and a Triennial Report) which will be reviewed by the Administration on Developmental Disabilities for compliance. This will provide us with feedback if we are deficient.

Contracts/Grants with DDPAC are evaluated via Quarterly Reports and evaluation by DDPAC staff and Council member. (See example in Attachments.)

We anticipate (by July, 1983) to begin a yearly Survey of Client Satisfaction to obtain feedback from clients served as to our effectiveness.

8. Special Programs

None at this time. We are the only agency providing this type of advocacy for developmentally disabled persons in the State, so we are special.

9. Attachments

Attached: Most recent Statistical Report
Most recent DDPAC Quarterly Report

Optional: In external evaluation of DD/MAP by Harold Russell Associates of Waltham, Massachusetts, we quote: "Individual case advocacy has been the focus of DD/MAP's program, and it is in this area that its results are most impressive. While handling some very difficult cases that do not have obvious or even existent solutions, it was reported by all the representatives of advocacy organizations interviewed that DD/MAP will

not give up until a solution has been reached....DD/MAP has an excellent reputation in the community...The clients interviewed were highly satisfied with the way in which their cases were handled by the staff. They cited the personal and supportive approach of the staff combined with professional consistency, thoroughness and willingness to pursue all options in an effort to resolve the case, as the reason they achieved the results they had...".

DD/MAP, Inc.
Developmental Disabilities Montana Advocacy Program, Inc.

1219 E. 8th Avenue
Helena, Montana 59601
(406) 449-3889

CLIENT STATISTICS FOR 2ND QUARTER - FY 83

JANUARY THRU MARCH, 1983

* *

	Carryover	New	Closed	Open
SEX:	69	23	13	79
Male	50	16	11	55
Female	21	8	2	27
	71 a	24	13	82a
AGE:				
0-2	3	0	0	3
3-4	1	1	1	2
5-21	28	3	5	26
22-40	32	11	6	37
41-64	5	8	2	11
65+	0	0	0	0
	69	23	13	79
GEOGRAPHICAL AREA:				
Institution	16	5	0	21
Rural	9	5	2	12
Small town	38	10	6	42
Urban	6	3	5	4
	69	23	13*	79
RESIDENCE TYPE:				
Foster home	4	5	2	7**
Group home	14	3	5	12
Independent	8	1	0	9
Institution				
WSSH	5	0	0	5
BRS&H	11	0	0	11
Eastmont	0	3	0	3
Co. Jail	0	1	1	0
Nursing home	3	3	0	6
Parents	21	2	2	21
Semi-independent	3	3	1	5
Supervised SIL	1	0	1	0
Private group home	0	1	1	0
Personal care home	0	1	0	1
	70 b	23	13	80 b

*Movement: Small town to urban area
**Movement: Parents to foster home

a 3 cases consist of both male and female (two group and one couple)
b 1 client = group living in group home and foster home

DD/MAP, Inc. (continued)

2nd Quarter Statistics - continued

	Carryover	New	Closed	Open
LOCALITY:				
Region I	10	4	1	13
Region II	5	3	2	6
Region III	8	2	2	8
Region IV	33	9	5	37
Region V	13	5	3	15
	69	23	13	79
REFERRANT:				
Advocate/Friend	6	0	0	6
Board member	3	0	0	3
Board of Visitors	2	0	0	2
Consumer Group	1	0	0	1
DDPRC	1	0	1	0
Human Rights	1	0	0	1
Outreach	4	0	0	4
Other P&A	0	1	0	1
Parent	3	1	0	4
Private attorney	1	0	0	1
Private psychol.	1	0	0	1
Provider:				
dd	12	5	3	14
institution	8	0	0	8
mental health	2	0	0	2
school	1	0	0	1
social work	11	9	4	16
voc. rehab.	2	1	1	2
Self	2	0	0	2
State Agencies				
DDD	6	6	3	9
OPI	1	0	0	1
DDPAC	1	0	1	0
	69	23	13	79
PROBLEM AREA:				
Abuse/neglect	1	4	2	9
Consent	0	1	0	1
Criminal jus. iss.	4	2	1	5
DD Def.	3	0	0	3
Deinstitutional.	5	0	0	5
Dignity	0	1	0	1
Discrimin. gen.	0	1	1	0
Education	17	2	1	18
Emply. dis.	2	0	0	2
Evaluation	4	0	0	4
Finances	1	0	0	1
Guardianship	2	2	0	4
Habilitation	30	0	1	29
Health related	0	1	0	1
Independence	2	0	1	1
Inapp. Sex. Behav.	0	1	0	1

DD/MAP, Inc. (continued)

2nd Quarter Statistics - continued

	Carryover	New	Closed	Open
PROBLEM AREA (Continued)				
Medicaid	2	2	1	3
Medical care	6	2	1	7
Mental Health	1	0	0	1
P.T.	1	0	0	1
Parental interfer.	1	0	0	1
Parental rights	2	0	0	2
Personal freedom	2	0	1	1
Placement	18	10	4	24
Residential prog.	3	0	0	3
Rgts in community	10	2	2	10
Rgts in institut.	3	0	0	3
Sexual assault	1	0	0	1
SSI	7	1	3	5
Sup. Ser. entitle.	2	2	1	3
Voc. Placement	1	0	0	1
Voc. Rehab.	2	0	1	1
	133	34	21	146
PRIMARY DISABILITIES:				
Autism	7	2	2	7
Behavior problem	13	1	1	13
Blind	2	0	0	2
Partial blind	0	1	0	1
Brain stem injury	4	0	1	3
C.M.I.	1	0	0	1
C.P.	4	1	1	4
Deaf	1	0	0	1
Epilepsy	1	0	0	1
L. D.	3	0	1	2
M.R.	22	15	7	30
M.R.-M.H.	2	1	0	3
Multiple handicap	6	1	0	7
Prader-Willie	2	1	0	3
Other	1	0	0	1
	69	23	13	79
FUNCTIONAL LIMITATIONS:				
Self care	31	8	3	36
Language	31	7	4	34
Learning	57	21	11	67
Mobility	16	2	1	17
Self-direction	63	20	13	70
Independent liv.	58	19	12	65
Economic suffic.	62	18	10	70
Infant at risk	3	0	0	3
	321	95	54	362

DD/MAP, Inc. (continued)

2nd Quarter Statistics (continued)

CLOSED CASES:	Successful	10
	Unsuccessful	0
	Other	3
		13

Remedies Used in 2nd Quarter:

Information	12
Consultation	9
Adm Remedy	0
Negotiation	0
Inquiry	1
Supervised referral	2
	24

DD/MAP, Inc.
Developmental Disabilities Montana Advocacy Program, Inc.

1219 E. 8th Avenue
Helena, Montana 59601
(406) 449-3889

24 March, 1983

TO: Mary Faye Boyd

FROM: Margi Ulvestad

RE: Third Quarterly Interim Report
December 1, 1982 through February 28, 1983
Contract Grant #82-154-3222

1. CURRENT ACCOUNTING OF ALL MONIES: 75% time elapsed

% Spent	Item	Budget	This ¼	To Date	Balance
62%	Travel	2898	498	1810	1088
75%	Attorney	1920	480	1440	480
14%	Manual	3535	483	483	3052
		8353	1461	3733	4620

MATCH: We have already met our match requirements.

2. DD PERSONS SERVED by age, sex and disability. Below is information regarding new clients served during this time period who reside outside of Region IV. A complete set of statistics can be found in Attachment A.

AGE:		SEX:	
0-2	0	Male	6
3-4	0	Female	6
5-21	1		12*
22-40	8		
41-64	2		
65+	0		
	11		

* 1 "client" includes group with both male and female members.

DISABILITY - Primary categorical diagnosis causing the person to request services from DD/MAP:

Mental retardation	8
Prader-willie	2
	11

Functional limitations include:

Self care	2	Independent living	11
Language	2	Economic Sufficiency	9
Learning	11		46
Mobility	0		
Self-direction	11		

DD/MAP, Inc. (continued)

During this grant period of June, 1982 through February, 1983, we have served a total of 35 new clients from outside of Region IV.

3. PROJECT OBJECTIVES AND PROGRESS THERETO:

1. To increase staff capability to provide on-site advocacy services to dd persons living outside of Region IV.

We served 11 new persons outside of Region IV during this reporting quarter (December, January, February); we served a total of 20 new clients. Our total caseload outside of Region IV is now (32+11-4) 39; our total caseload as of 2/28/83 is (68+9-2) 75.

3rd quarter (April-June) 6 of 19 new clients 32%
1st period DDPAC (June-Aug) 10 of 18 new clients 56%
2nd period DDPAC (Sept-Nov) 14 of 17 new clients 82%
3rd period DDPAC (Dec-Feb) 11 of 20 new clients 55%

While this period represents a decrease from last period, it does represent an increase from before the grant was granted.

Location of new clients served:

	Dec-Feb	Previous	To date
Region I	2	6	8
Region II	2	3	5
Region III	2	4	6
Region IV	9	11	20
Region V	5	11	16
	20	35	55

The most evident benefit of this contract to meet this objective are monies to allow staff to travel to localities outside of Region IV to provide on-site advocacy services to clients. Below are the staff travels during this period:

Destination	# clients	Cost
Hamilton	3	72.50
Billings	3	52.30
Missoula, Ronan, Polson	3	121.20
Missoula	1	50.50
Kalispell, Libby, Thompson Falls, Plains	4	171.00
		498.00

Further details about travel costs and activities included in Item 6.

Client Satisfaction Forms - no progress

DD/MAP, Inc. (continued)

2. To increase DD/MAP's capability to provide legal consultation and representation.

To accomplish this goal, we were able to add 16 hours per month to our attorney's time. He is now paid for a total of approximately 56.8 hours per month. He did provide us with these hours.

The attorney did not take on any new cases - we transferred one to him; thus a total of 7. He provides legal consultation to staff regarding just about every case we carry - this continues.

Location of cases:

Region I	1
Region II	1
Region III	2
Region IV	3
Region V	0

Transfered case includes accounting of institutionalized persons financial status via conservator.

Types of service during this time period:
- Consultation with staff
- Preparation of brief in response to appeal to OPI
- Consultation regarding Legal Rights Manual
- Travel to Glasgow to successfully handle SSI appeals.
- Consultation with other professionals

Number of hours: Total hours due = 56.8x3 = 170.4. Total hours worked (or recorded) = 166.75. He will make up the difference in the next time period.

December	53.5 hours
January	36.5 hours
February	76.75 hours

Client satisfaction forms - no progress

Status of cases:
- 4 pending hearing date
- 1 pending official decision (hearing done)
- 1 preliminary action
- 1 pending response from another party

3. To increase the capability of dd persons, family members, advocates, and professionals to assist in the protection of a dd person's rights via a rights manual.

During this period we sub-contracted with Leslie Taylor and Jim Reynolds, two local attorneys, for the development of a rights manual. (Contract attached) Initial consultative

DD/MAP, Inc. (continued)

meetings have been held between DD/MAP Executive Director and Leslie and Jim to decide areas to be covered, general set-up of the manual, etc. Work has begun on written portions.

4. IHP Plans - N/A

5. PROBLEMS - still the same old song!

6. OTHER:

A. Travel details

1. December 1, 1983: to Hamilton for an IHP meeting for a severely multiply handicapped person - concern for appropriateness of placement (nursing home located 15 miles from day program) - decision of team to explore options and maintain placement for now. Independent team will look at client. Team will look at alternative placements. While there, staff consulted with social worker about two other clients - one who also needs more appropriate placement plus mental health services and one who is in foster home placement in another community, but state/county has not paid foster home level of care as directed by court (child declared youth in need of supervision). Staff contacted state upon return - correct level of funding will be provided (judge had already declared that state would be in contempt of court if the level was not honored; staff remined state of that status).

2. November 23-34, 1982 (paid in December): to Billings to "lobby" for acceptance of 3 clients into new group homes. Only one was accepted, but interest is clear in another for potential future opening.

3. December 20-21, 1982: to Missoula, Ronan, and Polson to (1) meet with parent of disabled child to sort out problems in almost every aspect of life - from SSI mess to assistance to surgery to application for benefits for family to encouragement of parent to trust local resources; (2) attend IHP for client who continues to exhibit some behavior problems - and visit classroom to view program there; and (3) visit possible alternative placement for client in item #1.

4. January 18, 1983: to Missoula to investigate alleged abuse situation of dd person in private group home; visit included meeting with all social workers and licensing personnel as well as visit to the group home. Situation is resolved via (1) independent removal of client from that group home and acceptance into another and (2) our written recommendation for alterations to group home board of directors.

DD/MAP, Inc. (continued)

4. January 4, 1983: to Missoula to attend IHP team meeting for a client exhibiting behaviors jeopardizing her continued placement there.

5. January 12-14, 1983: to Kalispell, Libby, Thompson Falls, Plains to (1) visit programs in Kalispell, (2) attend IHP meeting in Libby for individual to discuss least restrictive setting in view of individual's particular disability/problem and discern client's wishes, (3) consult with school officials regarding future placement of school student requiring more appropriate placement, and (4) consulting with staff regarding alleged sexual assault on client(s) by proprietor of private residential facility and the welfare and potential placement of other individuals living in that same facility. Footnote: Item #2-client is in limbo becuase she is making so much currently at sheltered workshop that she no longer receives SSI - therefore entry into another facility is difficult financially --- but plans for movement continue. Item=4-individuals are being placed, facility is being closed.

B. Legal time expended serving clients - total of 166.75 hours.

C. Time spent on legal rights manual - approximately 6 hours by DD/MAP staff and an unknown number by attorneys - major section on guardianship was written during this time period. Amount of money spent - $420 to attorneys and $63 for advertising for bids for a total of $483.

Final comment: If you thought the trip to Libby was long-wait til you see the trips to eastern Montana coming up. Again - our appreciation is extended to DDPAC for the funds and to DDPAC staff for their support.

DD/MAP, Inc.
Developmental Disabilities Montana Advocacy Program, Inc.

1219 E 8th Avenue
Helena, Montana 59601
(406) 449-3889

STATISTICS - NEW CLIENTS

December, 1982; January and February, 1983

SEX:	Male	14
	Female	7
		21*
AGE:	0-2	0
	3-4	0
	5-21	2
	22-40	11
	41-64	7
	65+	0
		20
GEOGRAPHICAL AREA:		
	Urban	4
	Rural	4
	Small town	11
	Institution	1
		20
RESIDENCE TYPE:		
	Group home	8
	Independent	1
	Institution	1
	Nursing Home	1
	Parents	2
	Semi-Ind. Living	4
	Private GH	1
	PCH	1
	Co. jail	1
		20
LOCALITY:		
	Region I	2
	Region II	2
	Region III	2
	Region IV	9
	Region V	5
		20
REFERRANT:		
	Provider:	
	dd	4
	social work	9
	other - VR	1
	Parent	1
	DDD	5
		20

PROBLEM AREA:	
Abuse/Neglect	4
Criminal related	2
Dignity	2
Discrimination	1
Guardianship/ Conservatorship	2
Medical Care	2
Placement	7
Rights In Community	2
Medicaid	1
SSI	1
Other Support Ser. Entitlements	3
Voc	1
Consent	1
Health related	1
Inapp. sex. beh.	1
	31
PRIMARY DISABILITY:	
Autism	1
Behavior Problem	2
M.R.	14
MR-MH	1
Prader-Willie	2
	20
FUNCTIONAL LIMITATIONS:	
Self care	5
Language	2
Learning	20
Mobility	0
Self-direction	20
Independent living	18
Economic sufficiency	16
	81

* 1 couple

SECTION 3.9

SCOPE OF SERVICES

EASTMONT HUMAN SERVICE CENTER

EASTMONT

1. Profile of Current Services

Eastmont Human Services Center, located in Glendive, Montana, is a state-owned and operated residential facility under the administrative direction of the Department of Institutions, Division of Mental Health and Residential Services. In June, 1983, Eastmont discontinued its five day residential program to allow expansion of the seven day program which currently serves approximately 55 residents. Eastmont's residents come from across the state with the majority of residents having been previously residents of Boulder River School and Hospital and transferred to Eastmont to receive services in a smaller, residential setting.

Training and habilitation at Eastmont is provided in seven major areas: Academics and Pre-Academics, Self-Help Skills, Socialization, Pre-Vocational Training, Recreation Therapy, Home Living Training and Speech and Language Training. Community activities and interaction are actively encouraged as part of the ongoing program and every effort is made to keep parents and families involved in the resident's programming.

Figure 1 illustrates the administrative organization of Eastmont. For the FY84-85 biennium, Eastmont has been authorized 94.02 FTE for FY84 and 94.02 FTE for FY85. Eastmont's total budget during the biennium:

	FY84	FY85
State Funds	$2,049,066	$2,059,415
Federal Funds	4,984	4,984
TOTAL	$2,054,050	$2,064,399

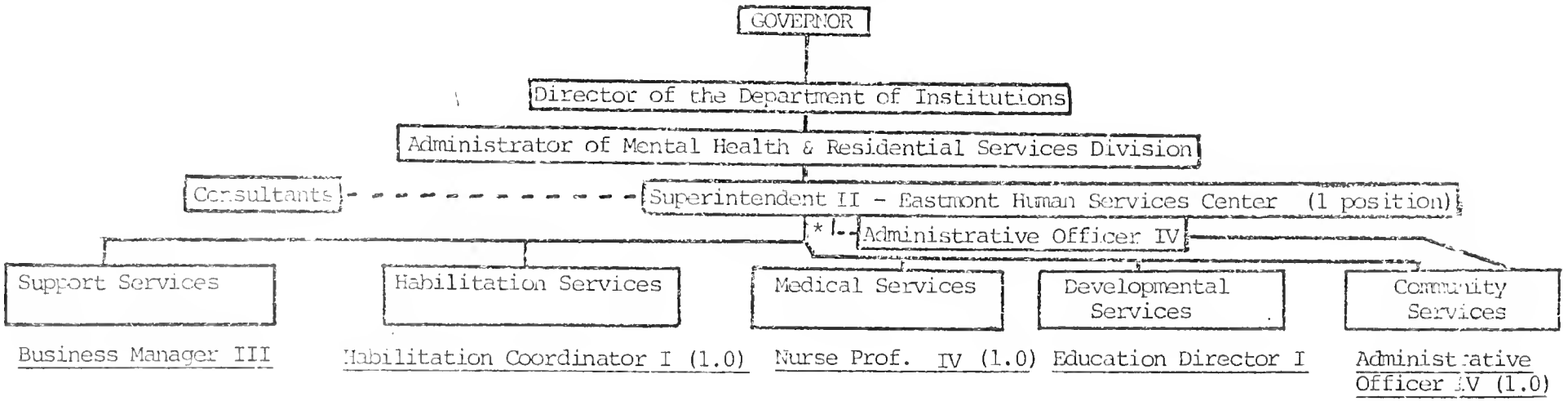
Admissions to Eastmont are processed by the Community Service Department (contact Superintendent, 365-6001) with consultation of other professional staff at the Center. All admissions must be in accordance with Montana's commitment law (53-20-125, MCA or 53-20-129, MCA for an emergency admission). There are no age limits for admission to the program. Discharges from the program occur when an appropriate placement becomes available in the resident's home community or when an opening occurs in a community-based service system. All placements into the community are made with the cooperation of school officials, the staff of the community service which will be serving the resident upon discharge from Eastmont, and the Developmental Disabilities Division, SRS. Referral information includes a copy of the complete Individual Habilitation Plan and support information.

2. Generic Services

Eastmont employs a variety of generic services to supplement the programs provided directly by staff of the Center. Those services include medical consultation and use of county hospital and dental facilities, contracts with private therapists to provide physical therapy and occupation therapy. Eastmont residents also participate in special education programs in the public school system. Additionally, Eastmont residents participate in community recreational activities including movies, bowling, camping, restaurants and shopping trips.

EASTMONT HUMAN SERVICES CENTER

ORGANIZATIONAL STRUCTURE



*This position acts as the Superintendent during his absence, plus performs additional administrative duties as directed by the Superintendent.

3. Implementation Schedule and Responsible Agencies

At the beginning of each regular school year, each resident is evaluated using the Eastmont Adaptive Functioning Checklist. This checklist evaluates the resident's level of functioning in each of the training areas mentioned above in #1, and allows the professionals from the various disciplines of training to make specific recommendations for programming for the coming year. These recommendations serve as the basis for the resident's program, which lists the specific training areas the resident will be involved in, as well as listing specific time lines for goal achievement. The Individual Habilitation Plan is reviewed each month and appropriate additions and deletions are made to the program. The Individual Habilitation Plan lists the program area responsible for implementation of identified habilitation goals.

4. Expansion Plans

There are no expansion plans intended during FY84 through FY85.

5. Summary of Service Population

Figure 2 presents the Eastmont population according to sex, age, group, level of retardation and racial distribution.

6. Service Gaps

a. Due to the considerable distance from major population centers, Eastmont is unable to provide adequate inservice training or continuing education programs for professional staff, to include training of consultants with the special problems experienced by the mentally retarded.

b. The location of Eastmont has created problems in recruitment of professional staff and has necessitated contracting for certain professional services from as far away as Billings.

c. There are an insufficient number of age appropriate and barrier free community placement opportunities for Eastmont residents who, if such resources were available, could be transferred to a less restrictive environment.

d. Eastern Montana does not have adequate adaptive equipment facilities. There is neither an adaptive equipment laboratory available or sufficient repair facilities available.

7. Program Evaluation

Eastmont maintains an ongoing internal evaluation procedure that monitors the progress of each resident and the overall quality of each program service area. Additionally, Eastmont's programs are periodically reviewed by the following agencies: Board of Visitors, Board of Health, State Fire Marshall, Office of Public Instruction, Department of Institutions, PSRO, Legislative Auditor, SRS.

FASTMONT

Levels of Retardation

	UNKNOWN	NORMAL	MILD	MODERATE	SEVERE	PROFOUND	TOTAL
MALES							
0-12	0	0	0	0	1	0	1
13-17	0	0	0	0	0	1	1
18-21	0	0	0	0	0	1	1
22-30	0	0	0	0	2	7	9
31-60	0	0	0	1	0	7	8
61-90	0	0	0	0	0	1	1
TOTAL	0	0	0	1	3	17	21
FEMALES							
0-12	0	0	0	0	0	0	0
13-17	0	0	0	0	0	2	2
18-21	0	0	0	0	0	2	2
22-30	0	0	0	0	0	14	14
31-60	0	0	0	0	0	15	15
61-80	0	0	0	0	0	1	1
TOTAL	0	0	0	0	0	34	34
BOTH SEXES							
0-12	0	0	0	0	1	0	1
13-17	0	0	0	0	0	3	3
18-21	0	0	0	0	0	3	3
22-30	0	0	0	0	2	21	23
31-60	0	0	0	1	0	22	23
61-90	0	0	0	0	0	2	2
TOTAL	0	0	0	1	3	51	55

RACIAL DISTRIBUTION

White.	51	92.0%
Indian	4	7.2%
TOTAL	55	100.0%

8. Special Programs

Eastmont operates a Foster Grandparent Program that integrates the activities of foster grandparents into the overall habilitation programs of the facility. This program has proved to be of considerable benefit to both the residents of the facility and and the foster grandparents.

9. Appendices

N/A

SECTION 3.10

SCOPE OF SERVICES

HEALTH SYSTEMS AGENCY

What follows here is the executive summary from the Montana Health Systems Agency (MHSA). The complete 1981-84 Health Systems Plan is a detailed documentation of health-care delivery patterns in Montana. The components of the plan are numerous and complex. As the 1984 Plan Year progresses, DDPAC staff will work with MHSA staff to single out and reformat health systems information related to the specific needs of and services for persons with developmental disabilities. The complete plan is, however, available for reference at the DDPAC office and, also, at the MHSA office in Helena.

1981-84 HEALTH SYSTEMS PLAN

Executive Summary

The 1981-84 Montana Health Systems Plan (HSP) is presented through the efforts of volunteer health care professionals and lay public consumers to delineate and prescribe desired health care delivery patterns in Montana. The 1981-84 HSP was developed in accordance with the mandates of Public Law 93-641, as amended by the Health Planning and Resource Development Amendments of 1979, Public Law 96-79. These mandates are pursued by Health Systems Agencies (HSA's), totaling over 200 nationally. In Montana, one Health Systems Agency is designated for this purpose.

As the third revision to the initial 1978 Health Systems Plan, health care services addressed have been expanded to include additional components in the primary, secondary, and preventive/risk reduction service categories. All plan components have reassessed and updated through public review to best reflect current health care delivery status and future expectations of need. In so doing, the Montana Health Systems Agency (MHSA) developed guidelines, goal and objective statements, long-range recommended actions, review criteria and MHSA policy statements for twenty health care services and three health status problems.

One intent of this document is to serve as a foundation for decision-making in the area of health planning and health resource development. The MHSA's primary mechanism for encouraging the development of prescribed health care services in Montana is through its review and advisory recommendations or review and approval/disapproval authority. All health care institutions contemplating major capital expenditures, the development of new services or an alteration in the number of licensed beds must submit such projects to review by the MHSA and the State Department of Health and Environmental Sciences (DHES). In these reviews, the MHSA recommends to DHES, which has final decision-making authority. In reviews of selected health programs for the Proposed Use of Federal Funds (PUFF), the MHSA has approval/disapproval authority.

In addition to its review function, the 1981-84 Health Systems Plan will this year lend itself to the development of Implementation Plan projects. In a departure from last year's HSP, long-range recommended actions now supplement all plan components. It is the intent of the long-range recommended actions to identify the health care resources necessary to accomplish the objectives and ultimately the goal statements, for each health care service addressed. Through objectives and goal achievements, a positive impact on the health care delivery system is possible.

The first health services discussed are tertiary services, encompassing the specialized, highly complex and expensive services characterized by relatively low levels of utilization, such as Radiation Therapy and End Stage Renal Disease. The MHSA supports the development of three regional tertiary centers in Montana -- Billings, Great Falls and Missoula. Many of the services have already been established in these cities and are sufficient to meet the needs of Montanans through 1985. For most of these services, exceptions to the national guidelines are needed to insure reasonable accessibility for all Montanans.

Next, the Plan addresses nine secondary services such as general hospital inpatient care, alcohol and drug abuse services, mental health services, comprehensive rehabilitation services and long-term care. The first two components of this section deal directly with hospital services and the issue national guidelines for hospital resource standards and occupancy rates. Complementing the component on mental health services and the concept of deinstitutionalization, a new component was incorporated into this year's plan on Intermediate Care/Mental Retardation Facilities.

In addressing primary health care services, two additional components were developed for inclusion in the 1981-84 HSP, Federal Primary Care Programs and Hospice Care Programs. Both components complement the Primary Health Care Personnel and Long-Term Care plan components respectively.

While the 1981 Health Systems Plan for Montana represents a departure from previous formats and emphasizes availability, accessibility and cost, the issue of prioritization of the individual plan components has not been accomplished. It is anticipated that the prioritization process, now that the HSP is complete with descriptions of services and recommended long-range actions, will take place in the third and fourth quarters of 1982. The prioritization of the plan components will be added to this basic health systems plan as a supplemental document.

SECTION 3.11

SCOPE OF SERVICES

HEALTH SERVICES AND MEDICAL FACILITIES DIVISION

HEALTH SERVICES AND MEDICAL FACILITIES DIVISION

Profile of Current Services

In January of 1983, the State Department of Health and Environmental Sciences underwent internal reorganization. Specifically, the former Health Services Division and Hospital and Medical Facilities Division were combined into the Health Services and Medical Facilities Division under Mr. George Fenner's administration. Three bureaus replace the programs under the old organization. They are: Dental and Health Education (Dr. Haggberg, Bureau Chief), Clinical Programs (Dr. Pratt, Bureau Chief) and Nursing Bureau (Judy Gedrose, R.N., Acting Chief).

Administration

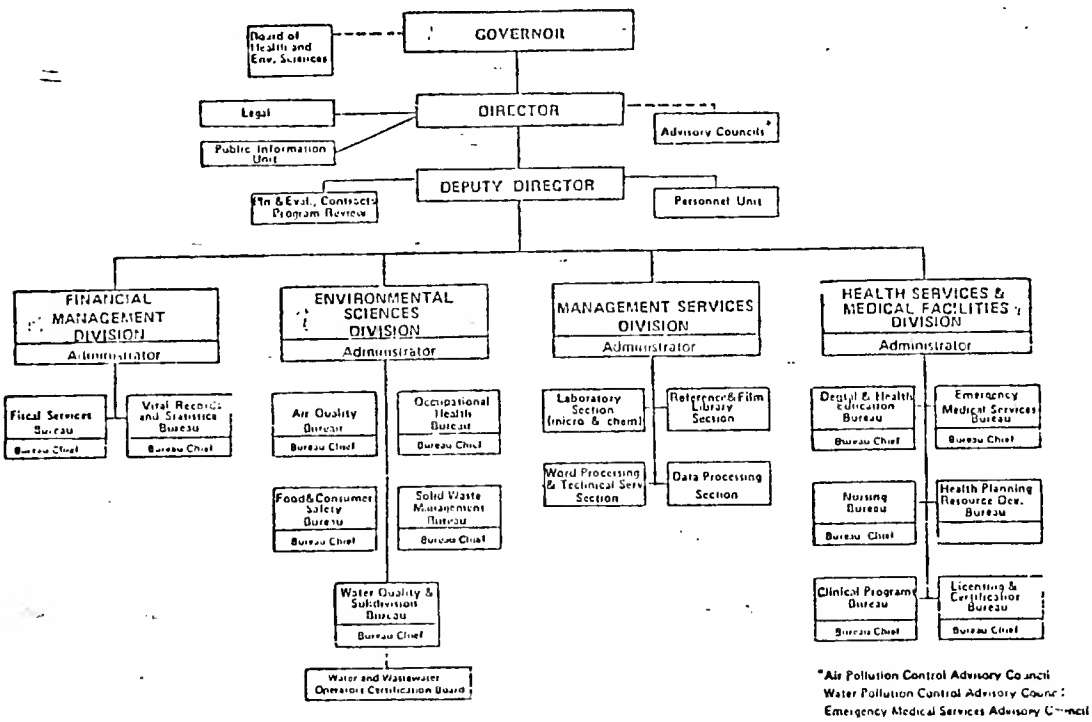
The Clinical Programs, under Sidney Pratt, M.D., are those requiring medical direction and include Handicapped Children's Services, Nutrition Programs, Improved Pregnancy Outcome Program, and Tumor Registry.

The Nursing Bureau includes programs under the direction of public health nurses and are: Immunizations, Venereal Disease and Family Planning.

The individual program administrations are divided among staff who have planning, promoting and coordinating responsibilities in the following areas: nursing related services, family planning, nutrition services (Women, Infants, and Children program), high risk pregnancies and children who have congenital defects and chronic handicapping conditions.

The delivery of services is accomplished by a combination of direct administration by the Bureaus and by contracting for specific services through local public agencies.

A LOOK AT THE NEW DEPARTMENT STRUCTURE



SERVICES

Programs

The health programs which have the greatest impact upon development disabilities services are Handicapped Children's Services, Improved Pregnancy Outcome Program, nutrition services, Women, Infants, and Children (WIC) program, nursing services, and Family Planning.

The following are program descriptions:

Nursing Bureau Programs:

1. Nurse related services include

   a. Maintenance of well child services for preschool children throughout the State by utilizing MCH block grant funds. This is an elective program on the part of interested counties. The well child clinics should insure early case finding and intervention to alleviate the effects of potentially handicapping conditions.

2. State Nursing Consultants

   The State level nursing consultants act as links between HCS and local health care providers such as public health nurses. They provide consultation regarding available resources and specific information regarding various defects and their implications.

3. Family Planning

   In Montana, 20,522 clients were served by programs in 1981. This is a 464 percent increase in caseload since the program's statewide inception in 1972.

   Each Program functions under the medical supervision of a licensed physician.

   Family Planning meets the needs of those who otherwise cannot afford services and could eventually become dependent on government agencies.

   - The cost to the government for a mother on welfare and an unplanned child averages $3,348 per year plus food stamps and Medicaid.
   - The average cost per family planning medical encounter is $18.
   - The short-term benefits (savings) to federal, state, and local governments are estimated to be $2 for each dollar invested in family planning.
   - The long-term benefits are estimated to be $26 for each dollar invested.

Family Planning is a preventive health effort with potential to reduce significantly certain social, psychological and medical problems of women and children. It is characterized by two important aspects:

- Improvement of the health of women and children.
- The acceptance of family planning services must always be the voluntary decision of the individual.

The goal of Montana family planning services is to maintain or improve the reproductive health of Montana people in their reproductive years.

In Montana there are presently 15 family planning clinics. Currently the funding is provided by: Federal Title X monies through the Health Services Division of the Montana State Department of Health and Environmental Sciences; Federal Title XX monies through SRS; State funds (SFY 1982 - $22,950); third party reimbursement; local funds, and direct fees paid by the client based on the ability to pay. In addition some counties have elected to utilize MCH block grant funds for Family Planning. Total funds expended in SFY 1982 were $1,581,417 (including funds generated by local programs).

The preventative health based programs provide:

- counseling in all aspects of family life
- educational services
- physical examinations
- cervical cancer screening
- self-breast exams
- blood tests for anemia, rubella and syphilis
- immunization for rubella
- blood pressure recordings
- urinalysis for sugar and protein
- inter-agency referral for other problems
- dispensation of contraceptives
- screening and treatment for gonorrhea
- pregnancy tests

Family Planning services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women and children, particularly through the detection and prevention of cancer and venereal disease with women.
- Prevent birth defects and mental retardation. Mental retardation tends to be associated with prematurity and low birth weight. The Comptroller General's report to Congress on Mental Retardation, 1977 identified family planning programs as an existing program with the ability to make a significant contribution towards reducing the incidence of mental retardation.

- Reduce the incidence of abortion by preventing unplanned pregnancies.
- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects.
- Decrease maternal and infant mortality and morbidity.
- Assist couples who want to have children but cannot.
- Prevent unplanned pregnancies (particularly in child abuse and poverty situations).
- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.
- Assist couples in having the number of children they desire so that every child is intended and loved.

The Need:

- There are an estimated 52,799 women-in-need of subsidized family planning services in Montana.
- About 28 percent of these women (or 14,618) are being served by the 15 programs. Roughly estimated, an additional 16,896 women-in-need or (32 percent) are being provided family planning services by physicians.
- This leaves some 21,285 Montana women needing family planning services who are not receiving them. They are at risk for unplanned children.

Accomplishments:

- Seventy-one percent of the 20,522 clients served in 1981 lived in families with incomes at or below 150 percent of the CSA poverty level.
- Medical and/or education services were provided by programs to 20 unserved and 8 underserved counties in 1981.

In 1981 the 15 programs detected and referred for treatment:

- 390 positive pap smears for cervical cancer
- 1,361 cases of anemia
- 171 abnormal urine chemistry results
- 152 cases of gonorrhea
- 2,064 cases of vaginal infections

- 825 cases of breast diseases or other physical findings (heart, thyroid, etc.)
- 490 cases of high blood pressure

4. Clinical Bureau Programs

Handicapped Children's Services is administered by a program supervisor. Due to a significant reduction in federal funding, the program emphasis has changed. The program continues to offer multi-disciplinary evaluations through the Montana Center for Handicapped Children in Billings and Comprehensive Development Center in Missoula. In addition, Specialty Clinics for cardiac, cleft lip and palate, neurology and scoliosis are supported by HCS.

The component which assists family with purchase of the specialty care has experienced a great deal of change. The program capability to assist with the costs of maintenance care of long-term rehabilitative care no longer exists. The program is able to assist with costs related to corrective surgeries, related hospitalizations, limited therapies and appliances.

Eligibility Requirements:

Eligibility of HCS assistance is dependent upon the following criteria:

a. gross family income and family size

b. medical condition

c. under age 18

d. by receiving authorization from HCS before any care is provided

e. emergency care must be referred to HCS within 72 hours after services are begun.

The family gross income must be within 185 percent of poverty guidelines as established by the CSA guidelines, Federal Register, May 28, 1982.

Eligibility for program services begins from the date the referral is received by HCS.

Authorization for Service

All medical services to be paid by HCS must be preauthorized by Program Supervisor or Bureau Medical Director. Emergency notification of care must be called into HCS within 72 hours of the treatment. Record of such verbal authorization must be included in the patient's file.

The appropriate authorization forms are sent to the health care provider.

Acceptance of an authorization by the provider carries with it an agreement that HCS payment is accepted in full and the family is not billed for any balances. Exception to this may be determined and authorized by HCS staff and requires agreement by the family.

HCS has a maximum limit of $10,000 which may be spent per child per fiscal year. A fiscal year begins July 1 and ends the following June. When the $10,000 maximum is authorized for one procedure and costs are expected to exceed this limit, the family assumes responsibility for the balances.

No payment is made by HCS for unauthorized services for any care rendered before the date of referral.

Services Provided by HCS

a. Early identification of handicapping conditions is emphasized and efforts to increase such referrals are being stressed by WIC, Well Baby and Well Child Clinics.

   In addition, the Bureau of Vital Statistics provided the Clinical Programs Bureau Chief with copies of birth certificates identifying newborns with congenital malformations. The Bureau Chief also receives copies of certificates for fetal deaths, neonatal and infant deaths and Sudden Infant deaths.

b. Diagnostic Services

   Diagnostic evaluations of conditions are available to children on a pre-authorized basis. These may be arranged through a specialty clinic setting or through a single specialty provider.

   Eligibility for assistance with the cost of an initial specialty evaluation is determined by utilizing gross income, family size, and age. Payment for subsequent specialty evaluations is dependent upon income, age, and medical condition.

5. Improved Pregnancy Outcome Program (IPO)

The IPO program effort is focused on improving the outcome of a pregnancy for both the mother and the infant by reducing the neonatal and infant mortality. Emphasis is placed on offering continuing educational opportunities to hospital and PHN nurses working with this high risk population. As key component, IPO offers financial assistance for payment of specialized maternal testing of high risk mothers and emergency ambulance transport of mothers and newborns.

The eligibility criteria for financial assistance is the same as described for HCS.

The referrals to IPO for testing and transports must occur within 72 hours in order to be eligible for review.

In 1980, the infant mortality rate in Montana was 12.4 which was lower than the goal set forth in 1980-82. Efforts will be continued to reduce the infant mortality rate.

In 1980, the goal to reduce perinatal mortality rate to 15 was reached. Efforts will be continued to lessen the perinatal mortality rate even more.

6. WIC/Nutrition/Child Nutrition Components

Nutrition Services are part of the Clinical Programs Bureau. The primary objective of the Nutrition Program is to incorporate nutrition services into all health programs in Montana with the goal of improving the nutritional status of women of childbearing age and infants and children.

Nutrition Consultants provide technical assistance and training in understanding and disseminating valid technical nutrition information, determining nutrition needs, planning and in evaluating the impact of nutrition services as a component of ongoing comprehensive health care.

Within the Clinical Services Bureau, Nutrition is integrated into Dental, Nursing, Health Education, Family Planning, Improved Pregnancy Outcome, Handicapped Children's Services, and MCH and Preventive Health Block Grant Programs. The Special Supplemental Food Program for Women, Infants, and Children (WIC) and the Child Care Food Program (CCFP), statewide USDA nutrition program, are administered by the SDHES within the Clinical Programs Bureau.

The WIC Program provides (1) Nutrition Education and (2) Specified nutritious food supplements to pregnant and nursing women, and to infants and children up to 4 years of age who are determined by competent professionals (physicians and nutritionists) to be at "nutritional risk" because of inadequate nutrition and inadequate income. The program serves as an adjunct to good health care, during critical times of growth and development, in order to prevent the occurrence of possible health problems and improve health status. By improving the quality of nutritional care for the target population the objectives of the program are served; studies indicate WIC has made positive changes in the health of those served.

The CCFP Program provides funds to assist in nutrition education and in the purchase of adequate and nutritious food for children under 12 years of age enrolled in licensed public or nonprofit child care centers and outside-of-school-home care programs, in Head Start, in family or group day care homes. Specific meal patterns must be followed for all breakfasts, lunches, suppers and snacks served. Monthly reimbursements are provided to the facility based on the number and type of meals served and income of the child's family.

The objectives of the Nutrition Services Unit are:

a. To develop criteria for minimally acceptable nutrition services in Public Health Programs.

b. To establish and provide comprehensive, coordinated, public health nutrition services utilizing local dieticians and nutritionists who shall be responsible for providing technical assistance, consultation, direct services, referrals, program planning and evaluation services to providers and consumers.

c. To continue the provision of nutrition technical assistance and consultation to health care professionals throughout the state. This will be accomplished by incorporating nutrition information in at least 25% of the annual meetings of Nurses, Perinatal Association, Cleft Palate, Montana Public Health Association, Geriatric conferences, and other meetings as appropriate.

d. To establish a data base in the WIC participants which shall identify the prevalence of selected nutrition-related problems.

SECTION 3.12

SCOPE OF SERVICES

MENTAL HEALTH AND RESIDENTIAL SERVICES DIVISION

MENTAL HEALTH AND RESIDENTIAL SERVICES DIVISION

1. Profile of Current Services

As an administrative unit within the Department of Institutions, the Division of Mental Health and Residental Services does not provide any direct client services. Principal functions of the Division are the overall planning, budgeting and program monitoring of state operated residential facilities for the developmentally disabled (Boulder River School and Hospital, Eastmont Human Services Center), the mentally ill (Warm Springs/Galen State Hospital), psychogeriatric (Center for the Aged), and veterans (Montana Veterans' Home). In addition, the Division contracts with the five regional community health centers to provide community-based mental health services.

Figure 1 illustrates the current organization structure of the Division including the institutional programs directly supervised. For the FY84-85 biennium, the Division is authorized 5 FTE: Administrative Secretary, Operations Specialist, Evaluation and Planning. The Division's budget for the FY84-85 biennium including major programs administered:

	FY84	FY85
State	$40,175,110	$39,468,898
Federal	4,118,481	4,374,962
TOTAL	$44,293,591	$43,843,860

Inasmuch as the Division provides no direct services, all requests for admission to services should be directed to the particular agency to which admission is sought.

2. Generic Services

As noted above, the Division contracts with the five regional community mental health centers. Although their primary function is services to the emotionally disturbed, the centers do provide evaluation services to developmentally disabled as well as counseling and therapy to developmentally disabled persons with associated emotional problems.

Figure 2 shows the 5 regional mental health catchment areas and location of administrative and clinical offices.

For additional information on the community mental health program in a particular region, the following lists the Director, address of administrative office and phone number:

Frank Lane, Administrative Director
Eastern Montana Community Mental Health Center
1819 Main Street
Miles City, Montana 59301

Evan Crandall, Administrative Director
Golden Triangle Community Mental Health Center
P.O. Box 3048
2307 11th Avenue South
Great Falls, Montana 59403

William J. Wood, Regional Mental Health Director
South Central Montana Regional Mental Health Center
1245 North 29th Street
Billings, Montana 59101

David Briggs, Executive Director
Southwest Montana Mental Health Center
Airport Way Building West, Suite A
1300 Cedar Street
Helena, Montana 59601

G. Clark Anderson, Administrative Director
Western Montana Regional Mental Health Center
T-12 Fort Missoula
Missoula, Montana 59801

3. Implementation Schedule

N/A

4. Expansion Plans

No expansion of services are planned during the 84-85 biennium.

5. Summary of Services Provided

The Division provides no direct services. A summary of services provided by Boulder River School and Hospital and Eastmont Training Center may be found under the respective subchapters.

6. Service Gaps

a. Although communications have improved considerably, the overall DD system continues to experience discoordination due to the administrative split between institutional and community-based programs. The absence of a single administrative direction and philosophy hinders long range planning and coordinated allocation of scarce fiscal and professional resources.

b. Services to the developmentally disabled offender continues to be a serious service gap.

c. Coordination between community-based DD programs and community-based mental health programs could be improved to meet the joint interests of both the developmentally disabled and emotionally disturbed population.

7. Program Evaluation

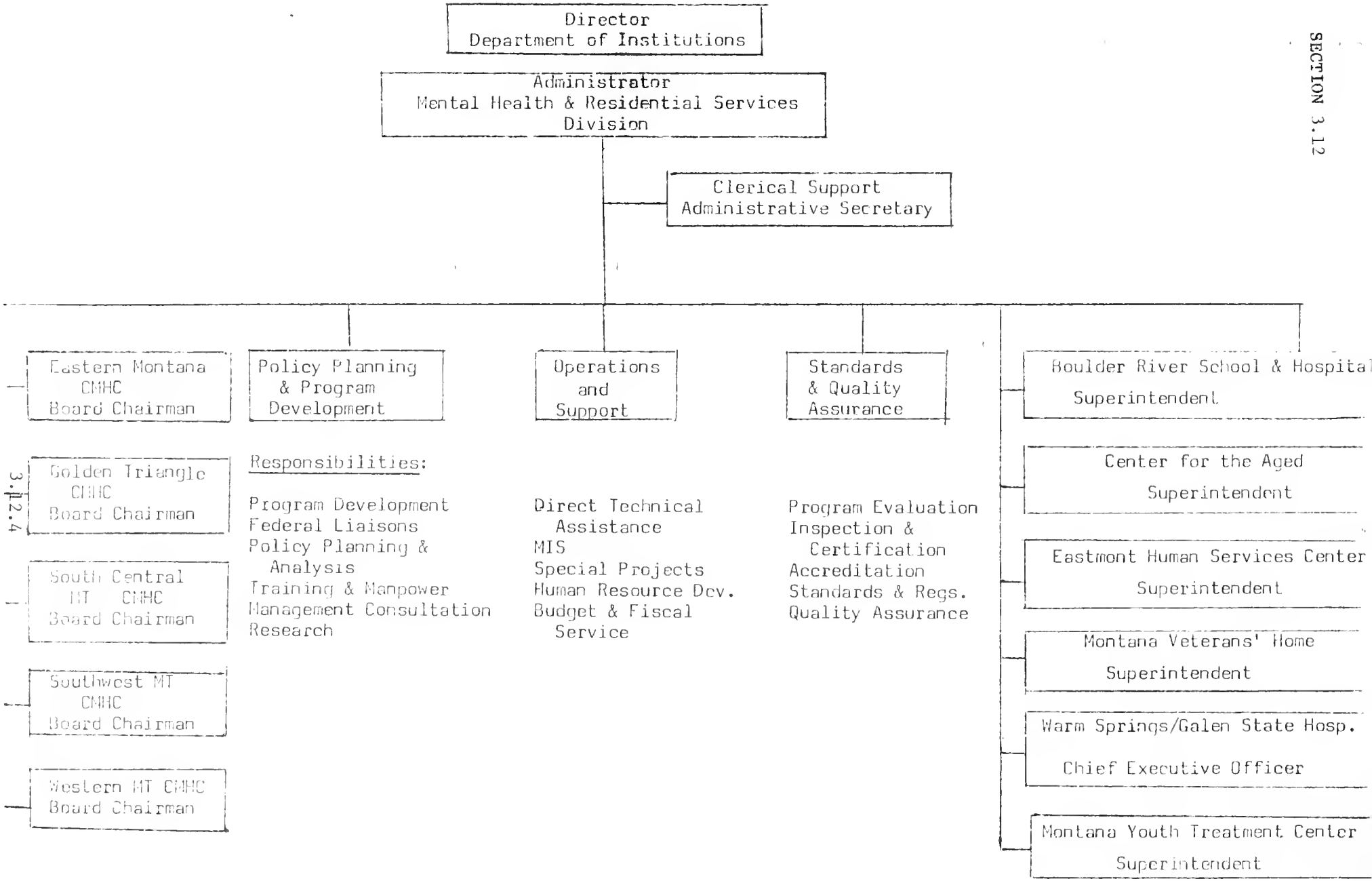
There is an extensive program monitoring system that the Division conducts of community mental health programs to include on-site visits to each program at least once per year. Program and fiscal evaluation of the institutional programs are conducted as enumerated in the subchapters of each institution.

8. Special Programs

N/A

9. Appendices

N/A



3.12.4

ORGANIZATIONAL CHART
MENTAL HEALTH AND RESIDENTIAL SERVICES DIVISION
Effective 1/1/83

MENTAL HEALTH SYSTEM (as of 10/1/82)

MONTANA

SECTION 3.13

SCOPE OF SERVICES

MONTANA CONFERENCE ON DEVELOPMENTAL DISABILITIES

I. Profile of Current Services

A. Persons Served

1. Staff of non-profit corporations that provide services to developmentally disabled citizens.

2. Staff of State agencies serving the developmentally disabled citizens.

a. Institutions - Direct care staff from Boulder River School and Hospital and Eastmont Human Services.

b. School Districts - Teachers and Teacher's Aids.

c. Staff of SRS, DDD Accounting Case Manager.

B. Access Points for Services

1. Carroll College, Helena, Montana

2. October 6-7, 1983

C. Agency Budget

1. DD/PAC Funds - $5,500.00

2. Matching Funds - $8,178.00

3. Total - $13,678.00

D. Staffing

1. TRIC Staff

a. Ted Spas, Coordinator

b. Marlene Kennedy, Editor/Librarian

2. Conference Staff (i.e., Speakers)

a. Dr. Richard Foxx - Anna Developmental Center

b. Dr. William Gardner - University of Wisconsin, Madison

c. Sonoma Developmental Center Training Team

d. Judith A. Williams - Sex Education Consultant, Sonoma Developmental Center

3. Generic Services - not applicable

II. Implementation Schedules and Responsible Agencies

A. Dates of Implementation - October 5, 6 & 7, 1983

B. Agencies responsible for funding:

1. Developmental Disabilities Planning and Advisory Council

2. Office of Public Instruction

3. Montana University Affiliated Program

4. State of Montana - Department of Institutions

5. State of Montana- Department of Social and Rehabilitation Services, Developmental Disabilities Division

C. Current Services

1. Topics to be covered in this year's conference

a. State of the art behavioral technology.

b. Treatment of mentally ill developmentally disabled citizens through mental health centers.

c. Sex education and the developmentally disabled.

d. Assertiveness.

e. Managing problem behaviors.

D. About thirty (30) paper presentations will be presented by conference participants.

E. Several rooms will be made available for "cracker barrel" discussions on select topics.

F. Priorities are set by the Montana Conference on Developmental Disabilities Steering Committee, which is composed of representatives of the funding agencies listed above and "provider" representatives.

III. Proposed or Tentative Expansion Plans

A. Next year's conference will be a three (3) day conference.

1. The first day will consist of special interest presentations/-discussions geared toward contemporary problems/issues in the field.

2. The first day will also include a "DD" fair. The purpose of this event will be to increase awareness of the accomplishments of persons with developmental disabilities and to disseminate information about available services in Montana.

3. Next year's conference will be held in early October, in a central location, possibly Billings. The estimated cost of next year's conference is about $15,000.00.

IV. Service Populations - (See I. Above)

V. Service Gaps

A. To service "minorities" generally are not targeted for attention during the DD Conference.

1. Child and Family Providers

2. Semi-Independent Living Providers

B. Semi-Independent living topics could be addressed at next year's conference during the first day in the special interest presentations.

VI. Evaluation

A. Both personnel and the program are evaluated in two ways:

1. A consumer questionnaire is disseminated to conference participants at the conference.

2. The Developmental Disabilities Planning and Advisory Council sends an evaluation team to the conference that evaluates the conference.

VII. Special Programs - Not Applicable

VIII. Appendices - Not Applicable

SECTION 3.14

SCOPE OF SERVICES

MONTANA SCHOOL FOR DEAF AND BLIND

MONTANA SCHOOL FOR DEAF AND BLIND

State Plan

1. Profile of Current Services

The State School is open to every visually and hearing impaired child in Montana--from birth through the age of 21. There is no charge for enrollment or for room and board.

Now a contemporary complex on an 18 acre campus in Great Falls, the Montana School for the Deaf and Blind was established nearly 90 years ago at Boulder for Montana children with hearing and visual handicaps. Today more than 100 students attend from every corner of the state.

The school was moved to Great Falls in 1936, when a dormitory/classroom building was completed.

In 1971 an academic and administrative center was completed. A building program begun in 1981 replaces the original dormitory with two residential cottages and adds a food services building with dining room and a physical therapy center that houses a bowling alley, swimming pool, splash pool, locker rooms, physical therapy room, training room, weight room, lobby area and a gymnasium with seating for sports activities.

2. Generic Services

The Montana School for the Deaf and Blind offers its students the same academic subjects that public schools do, fulfilling the same Board of Public Education requirements. Added emphasis is on language development for the hearing impaired and life skills for the visually impaired.

Because classes at MSDB are small, individualized instruction is possible. If one way of presenting material doesn't work for a student, another can be used.

All students attend classes in language, reading, mathematics, science, social studies, art, music, communication, home economics, and physical education. As they become ready, students go into the public schools for a portion of their school day.

Most of the visually handicapped students are ready to enter junior high school in their home districts. Hearing impaired students, because of their more difficult communication problem, usually continue their academic core subjects at MSDB, going into East Junior High School or Great Falls High School for electives.

The MSDB school year coincides with the public school year (See Table 3.1).

3. Implementation Schedules and Responsible Agencies

A child study team determines where and how a sensory-impaired child can receive the best education for his handicap--in the home school district or at MSDB. The team's evaluation usually takes place within six weeks after the child is considered for admission.

Parents of new students, as the nucleus of the team, might meet initially with one of the MSDB traveling resource consultants or the parent-infant advisor. Parent and child then come to the school for the child's on-site evaluation. (A spare room in one of the cottages is available for parents for a short orientation period as the evaluation begins.)

For the next four to six weeks, teachers work with the child to see how he gets along socially and educationally, and to determine educational recommendations. Classroom teachers evaluate the child's performance and skills in academic subjects. The school psychologist tests academic achievement, language, and intelligence. The audiologist assesses hearing loss. A physical therapist determines the kinds of help needed for special physiological problems and obtains a prescription if therapy is necessary. A counselor and house parent evaluate social development in the cottage environment.

Provided with all reports, the Child Study Team and parents meet with a representative of the home district. Together they determine if MSDB is the proper school for the student and (if it is) develop an individual education program (IEP) to fit the child's abilities and needs. Each member of the team (parents included) must sign the plan or file a minority report.

An annual review is required to ensure the best possible program for each child. However, anyone involved in the process can call a review meeting at any time.

Governance

Governance of the Montana School for the Deaf and Blind is entrusted to the appointive State Board of Public Education, which sets requirements for public education in the State. The Board's seven members serve staggered terms of seven years, meeting every four to six weeks. (Ex-officio nonvoting members are the Montana Superintendent of Public Instruction, the Commissioner of Higher Education, and the Governor.)

The school originally was administered by a superintendent. Assisting him now are the principal of the department of the hearing impaired, the principal of the department of the visually impaired and the department of the multi-handicapped, dean of students and the business manager.

4. Proposed Agency Expansion Plans (See Table 3.2)

5. Summary of Service Populations

a. Enrolled at Great Falls Campus 121

Hearing impaired 104
Visually impaired 12
Deaf/blind Multi-handicapped 5

b. Outreach and Itinerant Services 207

Parent/infant 36
Deaf/blind local 7
Visually impaired itinerant 164

c. Total served by Agency 328

6. Service Gaps

a. Parents of hearing and visually impaired children are areas where we have a gap in services due to lack of FTE's restricted by the Legislature.

b. Summer programming for hearing and visually impaired children has been eliminated due to funding cut backs.

To resolve both of these gaps, will take money and people. We are addressing these issues with the State Board of Public Education.

7. Program Evaluation Procedures

MSDB is evaluated on an annual basis by the State Board of Public Education, which is the State's governing body for public education.

Professional staff at MSDB must meet all certification requirements both state and national.

8. Special Programs (Information available upon request)

TABLE 3.1

MONTANA SCHOOL FOR THE DEAF AND THE BLIND
SCHOOL CALENDAR
1983 - 1984
(Proposed)

August 30, 31 & September 1	Orientation
September 5	10th, 11th & 12th Grade Students Travel to School
September 6	Preschool - 9th Grade Students Travel to School - Classes in Session
* September 23	Travel Home - Classes in Session
September 25	Travel Return
September 26	Classes Resume
* October 19	Travel Home P.M. - Classes in Session
* October 20	Travel Home - Students Travel A.M.
October 23	Travel Return
October 24	Classes Resume
November 5	End of 1st Quarter
* November 23	Travel Home - Classes in Session
November 24, 25, 26 & 27	THANKSGIVING VACATION
November 27	Travel Return
November 28	Classes Resume
December 15	Dress rehearsal for Christmas Pgm. - 10:30 A.M.
December 16	CHRISTMAS PROGRAM - 1:00 P.M. with reception to follow for parents, families and friends of the School.
* December 16	Travel Home - P.M. - Classes in Session
* December 17	Travel Home - Students Travel A.M.
December 17 through January 2	CHRISTMAS VACATION
January 2	Travel Return
January 3	Classes Resume
January 27	End of Semester - 2nd Quarter
* January 27	Travel Home - Classes in Session
January 29	Travel Return
January 30	Classes Resume
** February 17	Travel Home P.M. - Classes in Session
** February 18	Travel Home - Students Travel A.M.
February 21	Travel Return - Classes Resume
** March 23	Travel Home - Classes in Session
March 25	Travel Return
March 26	Classes Resume
March 30	End of 3rd Quarter
** April 19	Travel Home - Classes in Session
April 20, 21, 22, 23, 24 & 25	EASTER VACATION
April 25	Travel Return - Classes Resume
** May 25	Travel Home P.M. - Classes in Session
** May 26	Travel Home - Students Travel A.M.
May 29	Travel Return - Classes Resume
June 9	GRADUATION - 2:00 P.M. Saturday
June 13	Music Assembly - 10:30 A.M. Awards Assembly - 1:00 P.M. End of 2nd Semester - 4th Quarter
** June 13	Students who travel in P.M. Travel Home
** June 14	Students who travel in A.M. Travel Home
June 14	Teacher Check-Out

Teachers on duty August 30, 1983 through June 14, 1984

	PI Days	PIR Days
End of 1st Qtr. 11/5	42	5
End of 2nd Qtr. 1/27	42	0
End of 3rd Qtr. 3/30	49	0
End of 4th Qtr. 6/13	49	1
	182	6

Pupil Instructed	182
Pupil Instructed Related	6
Total Teacher Days	188
Total Student Days	182